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PROCEEDINGS
OF THE
MEDICAL SOCIETY
OF
LONDON.

VOL. I.
1872-1874.

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J. E. ADLARD, BARTHOLOMEW CLOSE.



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PREFACE.

THE Council, after due deliberation, lately directed that the 'Proceedings' of the Society should be published. By this resolution a permanent form is given to the labours of the Fellows, and to the discussions to which the communications gave rise.

It is to be regretted that such a step was not taken several years ago; but financial considerations were in the way.

Now that the Society is more prosperous than formerly, the Council are happy to be able to carry out this very useful measure.

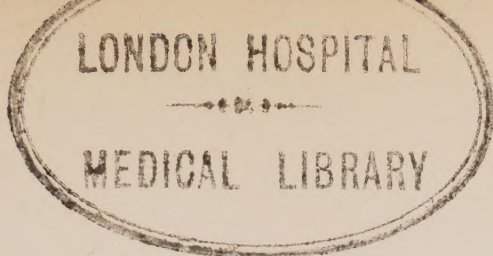
In presenting to the Fellows this important collection of abstracts of valuable papers, and a faithful record of the discussions, the Council desire to acknowledge the arduous labours of the Honorary Secretaries, Dr. Wiltshire, Mr. Woodhouse Braine, and Dr. Theodore Williams, who have carefully recorded the minutes; and to return thanks to the two latter gentlemen for the care they bestowed on the production of the 'Proceedings.'

These comprise a period of time between October 21, 1872, and May 4, 1874, viz. a winter session, under the presidency of Mr. Bryant; a full session, under the presidency of Dr. Habershon; and a spring session, over which Mr. de Méric presided.

The Council would also remind the Fellows that the present volume does not profess to be one of 'Transactions' such as are issued by many societies, but merely of 'Proceedings' containing an abstract of the business of the meetings; and they are fully aware of shortcomings, especially in the earlier portions, owing to the reports not having been made with a view to publication.

An Index, the work of Mr. Poole, the Registrar, will materially add to the usefulness of the work.

VICTOR DE MÉRIC, *President*.




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Subject for the Fothergillian Gold Medal for March, 1875:
"The Diseases of the Testicle and the Spermatic Cord."
For March, 1876: "On Cataract and its Treatment."

N.B.—Essays competing for the prizes are to be sent in before
the 1st of the preceding November.



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NATHANIEL HULME, M.D.	1776
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SAMUEL F. SIMMONS, M.D.	1780
JOHN SIMS, M.D.	1783
JOHN WHITEHEAD, M.D.	1784
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JAMES SIMS, M.D.	1786
J. C. LETTSOM, M.D.	1809
GEORGE PINCHARD, M.D....	1811
J. C. LETTSOM, M.D.	1813
JOSEPH ADAM, M.D.	...	...	...	...	...	1815
THOMAS WALSHMAN, M.D.	...	...	...	...	...	1817
HENRY CLUTTERBUCK, M.D.	...	...	...	...	...	1819
DAVID UWINS, M.D.	...	...	...	...	...	1821
WILLIAM SHEARMAN, M.D.	...	...	...	...	...	1823
HENRY CLUTTERBUCK, M.D.	...	...	...	...	...	1825
JOHN HASLAM, M.D.	1827
THOMAS CALLAWAY	1829
JOHN BURNE, M.D.	1831
WILLIAM KINGDON	1833
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LEONARD STEWART, M.D.	1839
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GEORGE PILCHER	1842
THEOPHILUS THOMPSON, M.D.	1844
WALTER COOPER DENDY...	1846
HENRY HANCOCK	...	...	...	...	...	1848
JOHN RISDON BENNETT, M.D. ...	...	...	...	...	...	1850

						ELECTED
E. W. MURPHY, M.D.	...	...	...	...	...	1851
JOHN BISHOP, F.R.S.	...	...	...	...	...	1852
FORBES WINSLOW, M.D., D.C.L....	...	...	...	...	...	1853
EDWARD HEADLAND	...	...	...	...	...	1854
JOHN SNOW, M.D.	...	...	...	...	...	1855
W. D. CHOWNE, M.D.	...	...	...	...	...	1856
FRANCIS HIRD	...	...	...	...	...	1857
W. H. WILLSHIRE, M.D.	...	...	...	...	...	1858
JOHN HILTON, F.R.S.	...	...	...	...	...	1859
ALFRED B. GARROD, M.D.	...	...	...	...	...	1860
WILLIAM COULSON...	...	...	...	...	...	1861
FRANCIS SIBSON, M.D., F.R.S.	...	...	...	...	...	1862
EDWIN CANTON	...	...	...	...	...	1863
ROBERT GREENHALGH, M.D.	...	...	...	...	...	1864
I. B. BROWN	...	...	...	...	...	1865
CHARLES J. HARE, M.D.	...	...	...	...	...	1866
HENRY SMITH	...	...	...	...	...	1867
BENJAMIN W. RICHARDSON, M.D., F.R.S.	...	...	...	...	...	1868
PETER MARSHALL	...	...	...	...	...	1869
JOHN GAY	...	...	...	...	...	1870
ANDREW CLARK, M.D.	...	...	...	...	...	1871
THOMAS BRYANT	...	...	...	...	...	1872
S. O. HABERSHON, M.D.	1873

Medical Society of London,

11, CHANDOS STREET, CAVENDISH SQUARE, W.

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All the above constitute the Council of the Society.

Registrar.

W. E. POOLE.

The List is revised to the end of July, 1874.

Committee for the Adjudication of the Fothergillian Gold Medal.

SUBJECT:—"On Diseases of the Testicle and Spermatic Cord."

For March, 1875.

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This Fund was instituted with the object of providing for the extraordinary expenses incident to the celebration of the Centenary and the removal to and furnishing of the new premises, &c.

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Diamond, W. H., M.D. (Twick-			Percival, J. T., M.D.....	1	1
enham)	2	2	Powell, R. Douglas, M.D.....	1	1
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Hare, C. J., M.D., F.R.C.P.....	5	5	Willetts, E. S., M.D.....	5	5
Hawksley, Thos., M.D.....	1	1	Wilson, Erasmus, Prof.....	5	5
Hill, T. H., Esq.....	1	1	Wiltshire, Alfred, M.D.....	1	1
Hird, Fras., F.R.C.S.....	1	1	Winslow, Forbes, M.D.....	5	5

Past Lettsomian Lecturers.

(THE LETTSOMIAN LECTURES COMMENCED IN 1851.)

SESSION

- | | | |
|---------|---|---|
| 1850-51 | { | G. OWEN REES, M.D., F.R.S., "On some of the Pathological Conditions of the Urine." |
| | { | G. J. GUTHRIE, F.R.S., "On some of the more important points of Surgery." |
| 1851-52 | { | FORBES WINSLOW, M.D., "On Medico-legal Evidence in Cases of Insanity." |
| | { | HENRY HANCOCK, F.R.C.S., "On the Anatomy and Physiology of the Male Urethra and on the Pathology of Stricture of that Canal." |
| 1853-54 | | E. W. MURPHY, M.D., "On Parturition as Illustrating the Importance of a Competent Education in the Practice of Midwifery." |
| 1854-55 | { | THEOPHILUS THOMPSON, M.D., "On Pulmonary Consumption." |
| | { | JOHN BISHOP, F.R.S., "On the Physical Constitution, Diseases and Fractures of Bones." |
| 1854-55 | { | FRANCIS SIBSON, M.D., F.R.S., "On the Influence of the Nervous System on Respiration and Circulation." |
| | { | FRANCIS HIRD, "On some Special Points in the Anatomy of the Uterus, and its Structural Lesions the Result of Inflammation." |
| 1855-56 | | None. |
| 1856-57 | | ALFRED B. GARROD, M.D., F.R.C.P., "Illustrations of the Pathology and Treatment of Gout." |
| 1857-58 | { | ROBERT BARNES, M.D., "On the Physiology and Treatment of Flooding from Unnatural Position of the Placenta." |
| | { | EDWIN LANKESTER, M.D., "On the History, Symptoms, and Treatment of Intestinal and other Worms Parasitic on the Human Body." |
| 1858-59 | { | FREDK. HEADLAND, M.D., "On the Advance during Modern Times of the Science of Medical Treatment." |
| | { | VICTOR DE MÉRIC, "On Syphilis." |
| 1859-60 | { | F.W. PAVY, M.D., F.R.S., "On Certain Points connected with Diabetes." |
| | { | ANDREW CLARK, M.D., "On Certain Evidences of the Arrestment of Phthisis." |
| 1860-61 | { | C. J. HARE, M.D., "Practical Observations on some of the Points of Difficulty in the Investigation of Tumours and Intumescence of the Abdomen." |
| | { | HAYNES WALTON, "On the Application of the Ophthalmoscope, and its Advantages." |

SESSION	
1861-62	{ B. W. RICHARDSON, M.D., F.R.S., "On Certain of the Phenomena of Life." F. W. MACKENZIE, M.D., "On the Pathology and Treatment of Phlegmasia Dolens."
1862-63	{ HENRY THOMPSON, "On Practical Lithotomy and Lithotrity." JAMES BIRD, M.D., "On Public and Private Hygiene."
1863-64	{ THOMAS BRYANT, "On the Surgical Diseases of Children." C. H. F. ROUTH, M.D., "On some Points connected with the Pathology, Differential Diagnosis, and Treatment of Fibrous Tumours of the Uterus."
1864-65	{ HENRY SMITH, "On the Surgery of the Rectum." J. L. W. THUDICHUM, M.D., "On Medicine: The Progress of Urology, with Practical Illustrations of its Value in the Diagnosis and Treatment of Several Diseases."
1865-66	F. E. ANSTIE, M.D., "On Certain Painful Affections of the Fifth Nerve."
1866-67	JOHN GAY, "On Varicose Diseases and Ulcers of the Lower Extremities."
1867-68	GEORGE BUCHANAN, M.D., "On the Diagnosis and Management of Lung Diseases in Children."
1868-69	WILLIAM ADAMS, "On Rheumatic and Strumous Diseases of the Joints, and the Treatment for the Restoration of Motion in Partial Ankylosis."
1869-70	TILBURY FOX, M.D., "Eczema: its Nature and Treatment."
1870-71	FRED. J. GANT, "On Excisional Surgery of the Joints; the Conditions appropriate for Excision; the Operations; After Treatment and Results."
1871-72	S. O. HABERSHON, M.D., "On the Pathology and Treatment of some Diseases of the Liver."
1872-73	HENRY LEE, "Urethral Discharges."
1873-74	W. H. BROADBENT, M.D., "On Syphilitic Affections of the Nervous System."

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1780 DR. KOYSTRAA.
1781 DR. SIMMONS.
1782 DR. WOOD.
1783 DR. JOHN SIMS (2nd).
1784 DR. WHITEHEAD.
1785 DR. RALPH. \
1786 —————
1787 MR. HOOPER.
1788 DR. MEYER.
1789 DR. DENNISON.
1790 DR. WALLIS.
1791 DR. SUTTON.
1792 DR. FRYER.
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1794 DR. GILBERT THOMPSON.
1795 JOHN ABERNETHY.
1796 DR. J. C. LETTSOM (2nd).
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1798 DR. FERRIS.
1799 MR. FORD.
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1801 MR. CHAMBERLAIN.
1802 DR. JOHN SIMS (3rd).
1803 MR. ANDRÆ.
1804 DR. J. C. LETTSOM (3rd).
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1806 MR. FIELD.
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1808 MR. JOHN MASON GOOD.
1809 DR. MEYER WALKER.
1810 DR. BIRKBECK.

Elected

1811 MR. BLAIR.
1812 DR. TEMPLE.
1813 MR. SAUMAREZ.
1814 DR. REES.
1815 MR. TAUNTON.
1816 DR. CLUTTERBUCK.
1817 MR. STEVENSON.
1818 DR. DAVID UWINS.
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1825 MR. LLOYD.
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1859	DR. C. H. F. ROUTH.
1860	JOHN GAY.

Elected

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1862	VICTOR DE MÉRIC.
1863	DR. S. O. HABERSHON.
1864	DR. J. L. W. THUDICHUM.
1865	DR. ROBERT GREENHALGH.
1866	WEEDEN COOKE.
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1871	DR. WILLIAM CHOLMELEY.
1872	FRED. J. GANT.
1873	DR. JOHN COCKLE.
1874	R. BRUDENELL CARTER.

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1787	W. FALCONER, M.D.
1790	R. WELLAN, M.D.
1791	J. C. LETTSOM, M.D.
1795	J. MASON GOOD.
1801	E. BOUTTATZ, M.D.
1803	E. JENNER, M.D.
1824	R. W. BAMPFIELD.
1828	J. G. PERRY.
1831	W. A. GUY.
1834	W. J. CLEMENT.
1835	G. MOORE.
1836	T. E. BRYANT.
1838	G. PILCHER.
1840	T. OSBORN.
1842	J. R. BENNETT, M.D.
1843	J. C. LEROW, M.D.
1844	H. P. ROBERTS.

1845	W. C. DENDY.
1846	R. M. GLOVER, M.D.
1847	R. STEDMAN.
1849	J. MILLIGAN.
1851	R. P. COTTON, M.D.
1851	R. HODGES.
1852	F. W. HEADLAND, B.D.
1853	A. POLAND.
1854	B. W. RICHARDSON.
1856	W. BURKE RYAN, M.B.
1857	E. CANTON, F.R.C.S.
1858	T. H. BARKER, M.D.
1859	A. T. H. WATERS.
1868	JOHN CLAY.
1870	T. S. CLOUSTON, M.D.
1872	EDWARDS CRISP, M.D.
1874	J. K. SPENDER, M.D.

Honorary Fellows.

- ARNOTT, J. M., Esq., F.R.S. (1830). P 2, C 2.
- ASHBURNER, J., M.D. (1825). P.
- BENNETT, J. RISDON, M.D. (1837; FM 1842), 15, Finsbury-square, Consulting Physician to St. Thomas's Hospital, and Physician to the Victoria-park Hospital. P 2, VP 2, C 7, O, S 3, ‡ 8.
- BURNE, JOHN, M.D., F.R.C.P., Richmond-lodge, Bath. P 2, VP 2, C 5, O, || 4, ‡ 5.
- BURROWS, SIR GEORGE, Bart., M.D., D.C.L., F.R.S., 18, Cavendish-square, W., President of the Royal College of Surgeons; Physician Extraordinary to H.M. the Queen; Consulting Physician to St. Bartholomew's Hospital; Member of the Senate of the University of London.
- CHAUVEAU, Professor, Lyons.
- CHRISTISON, SIR ROBERT, Bart., M.D., D.C.L., LL.D., 40, Moray-street, Edinburgh, Physician in Ordinary to H.M. the Queen in Scotland; President of the Royal Society of Edinburgh; Professor of Materia Medica in the University of Edinburgh.
- COULSON, W., F.R.C.S. (1843), 2, Frederick-place, Old Jewry, Consulting Surgeon to St. Mary's Hospital and to the German Hospital. P, VP, C, S, ‡.
- CUSACK, C., Esq., Paris.
- DUCHENNE, Professor, Boulogne.
- FARRE, ARTHUR, M.D., F.R.S., 12, Hertford-street, Mayfair, W., Physician-Accoucheur to H.R.H. the Princess of Wales.
- FISHER, SIR J. W., Kt., M.D. (1807), 33, Park-lane, W. P 2, VP.
- GUENEAU DE MUSSY, HENRI, M.D., 15, Rue du Cirque, Paris.
- HANCOCK, HENRY, F.R.C.S. (1838), 76, Harley-street, W., Senior Surgeon to Charing Cross Hospital. P 4, VP 5, C 8, LL, O, T 8, ‡ 14.
- HARE, CHARLES J., M.D., F.R.C.P., 57, Brook-street, W., late Professor of Clinical Medicine in University College, and Physician to University College Hospital, &c. P, VP 2, C, S, LL, ‡ 7, ||. (Elected Hon. Fellow 1869.) (*Trustee.*)
- HAWKINS, CÆSAR, Esq., F.R.S., 26, Grosvenor-street, Sergeant-Surgeon to H.M. the Queen, and Consulting Surgeon to St. George's Hospital, &c. C 2, S.
- HAWKINS, F., M.D., 16, Ashley-place, Victoria-street, S.W., Registrar of the General Medical Council, Physician to the Queen's Household.

- HEBRA, FERDINAND, M.D., Vienna, Professor of Dermatology.
- HELMHOLTZ, H., M.D., Berlin, Professor of Physiology in the University of Berlin.
- *HILTON, JOHN, F.R.S., F.R.C.S. (1845), 10, New Broad-street, E.C., Consulting Surgeon to Guy's Hospital and to the Royal General Dispensary, St. Pancras; Surgeon-Extraordinary to H.M. the Queen. p, vp, c 3, ‡ 2, sm.
- HUXLEY, THOMAS HENRY, LL.D., F.R.S., 26, Abbey-place, St. John's Wood, N.W., Professor of Natural History in the Royal School of Mines.
- JENNER, SIR WILLIAM, Bart., M.D., K.C.B., D.C.L., F.R.S., 63, Brook-street, W., Physician-in-Ordinary to H.M. the Queen and to H.R.H. the Prince of Wales; Professor of Clinical Medicine in University College, London, and Physician to University College Hospital.
- JOHNSON, H. J., Esq. (1843), 9, Suffolk-place, Pall-mall east, and Roehampton, Surrey.
- LANGENBECK, BERNHARD VON, M.D., Berlin, Professor of Surgery in the University of Berlin.
- LOCOCK, SIR CHARLES, Bart., M.D., D.C.L. Oxon. (1825), 26, Hertford-street Mayfair, Physician-Accoucheur to the Queen, &c.
- NORTH, JOHN, F.R.C.S., 9A, Gloucester-place, Portman-square.
- OLLIER, Professor, Lyons.
- OWEN, RICHARD, D.C.L., LL.D., F.R.S., Sheen Lodge, Mortlake, Superintendent of the Natural History Department in the British Museum.
- PAGET, SIR JAMES, Bart., D.C.L., F.R.S., 1, Harewood-place, Hanover-square, W., Sergeant-Surgeon-Extraordinary to H.M. the Queen; Surgeon-in-Ordinary to H.R.H. the Prince of Wales; Consulting Surgeon to St. Bartholomew's Hospital; Member of the Senate of the University of London.
- QUAIN, RICHARD, F.R.S., F.R.C.S. (1837), 32, Cavendish-square, Surgeon-Extraordinary to the Queen; Member of the General Council for the College of Surgeons; Emeritus Professor of Clinical Surgery, University College, and Surgeon to University College Hospital, &c. vp, c.
- ROKITANSKY, CARL, M.D., Vienna, Curator of the Imperial Pathological Museum, and Professor of the University of Vienna.
- SCANZONI, F. W. VON, M.D., Wurzburg, Professor of Midwifery in the University Wurzburg.
- SEAONE, M., M.D. (1835), Salamanca.
- SIGMOND, GEORGE G., M.D., L.R.C.P. (1833), Rue de la Paix, Paris. c 2.
- SMITH, J. GREGORY, F.R.C.S., Morley Hospital, Copse-hill, Wimbledon. vp, c 4.
- STOKES, WILLIAM, M.D., D.C.L., LL.D., F.R.S., 5, Merrion-square, Dublin, Regius Professor of Physic in Dublin University.
- TYNDALL, JOHN, LL.D., F.R.S., Professor of Natural Philosophy in the Royal Institution, Albemarle-street, Piccadilly, W.
- VIRCHOW, RUDOLPH, M.D., Berlin, Professor of Pathological Anatomy in the University of Berlin.

WEBSTER, JOHN, M.D., F.R.S., 20, Brook-street, W., Physician to the Scottish Hospital; Consulting Physician to the St. George's and St. James's Dispensary. c, t 3.

WILLIAMS, C. J. B., M.D., F.R.S. (1838), 49, Upper Brook-street, Physician Extraordinary to H.M. the Queen; Senior Consulting Physician to the Brompton Hospital for Consumption. || 2.

Corresponding Fellows.

Prior to the Session 1868-9.

Elected

- 1851 ALBARO, Sir D. J. MENDEZ, Madrid.
- 1861 ALVARENGO, PEDRO FRANCISCO DA COSTA, M.D., Lisbon.
- 1844 ANDREWS, WILLIAM, M.D., Cape of Good Hope.
- 1856 BAKER, ALBERT, M.D., Dawlish, Devonshire, Physician to the Dawlish Dispensary.
- 1855 BEARDSLEY, A., Esq., Bay Villa, Grange, Lancashire. ||.
- 1850 BENAVENTE, Sr. D. MARIANO, Madrid.
- BENEKE, F. W., M.D., New York.
- 1865 BOECK, Professor, Christiania.
- 1850 BÖHM, —, M.D., Vienna.
- BOTTANI, GIUSEPPE, M.D., Milan.
- BRANDER, J., M.D., India; in London, East India Club, St. James's square.
- 1865 BRAUN, Professor CARL, Vienna, Physician to the General Lying-in Hospital.
- 1837 BÜHRING, J. J., M.D., Berlin.
- 1850 BURKE, J. PAGE, M.D., Staff Surgeon, R.N.
- CADE, THOMAS CHARLES, Esq., Spondon, Derby.
- 1860 CALTHROP, W. C., Esq., Withern, Alford, Lincolnshire. sm.
- 1855 CLARK, A., Esq., Twickenham.
- 1855 COATES, CHARLES, M.D., 10, Circus, Bath, Physician Bath General and Royal United Hospitals. ||.
- 1850 COX, WILLIAM J., Esq., Hawkesbury, Upton, Gloucestershire. c.
- CRONIN, WILLIAM JAMES, F.R.C.S., the Lodge, Queenstown, Cork, Ireland. || 2.
- 1850 CURTIS, GEORGE, Esq., Dorking.
- 1851 CUTLER, EDW., M.A., Spa, Belgium.
- 1851 CZERMAK, JOHN, M.D., Prague, Professor of Anatomy and Physiology.
- DE MUYNCK, J., M.D., Ghent.
- 1865 DIDAY, PAUL, M.D., Lyons.

Elected

- 1836 DE SA, MANOEL CARVALHO PEREIRA, M.D., Rio Janeiro.
EKSTEIN, SIGISMUND, M.D., Vienna.
- 1851 ESCOLOR, Sr. D. SERAPIO, Madrid.
FYLANDT, JOHANN EMIL, M.D., Curland, Russia.
- 1865 FALCONER, RANDLE WILBRAHAM, M.D., F.R.C.P., F.K.Q.C.P. (Irel.),
22, Bennett-street, Bath, (Hon.) Senior Physician to the United and
Mineral Water Hospitals.
- 1853 FALLOT, R., M.D., St. Laurant d'Aigonzé, Montpellier, France.
- 1864 FEDETI, G., M.D., Rome.
- 1851 FLOR, Sr. D. JOSE PEREZ, Madrid.
- 1854 GREEN, HORACE, M.D., New York.
HARDING, GEORGE, Esq., East Indies, 37th Native Infantry, E.I.C.
- 1847 HASSALL, RICHARD, L.R.C.P., Richmond.
- 1864 HASENFELD, EMMANUEL, M.D., Pesth.
- 1867 HUGHES, J. S., M.D., Dublin.
- 1847 HUGHES, ROBERT, Esq., The Mount, Stafford, Surgeon, Stafford County
General Infirmary.
HYMAN, —, M.D., Antwerp.
- 1851 IIGUIERDO, Sr. D. SEBASTIAN OBTEGA, Madrid.
JACKSON, J. M., Esq., Madras, E.I.C. Madras Light Infantry.
JEYES, SAMUEL, M.D., Half-pay Staff.
- 1861 JOURNEZ, HENRI, M.D., 43, Rue de la Charité, Bruxelles, Belgique.
- 1852 JUNOD, THEODORE, M.D., Geneva.
KITCHING, G., M.D., M.R.C.P., Enfield.
- 1851 KÖLLIKER, ALBERT, M.D., Wurzburg, Professor of Anatomy and Physio-
logy.
LAX, WILLIAM, Esq., Ormskirk, Lancashire, Surgeon to the Ormskirk
Dispensary.
LEON, Sr. D. JOSE, Madrid.
- 1831 LINNECAR, E. H., Esq., Shenley, Herts. c 11, ‡ 3.
- 1851 LLANOS, Sr. ANTONIO CAMPO, Madrid.
- 1851 LOVERA, Sr. D. JOSE, Madrid.
- 1855 MARSDEN, WILLIAM, Quebec, M.D., Canada, Physician to the Marine
Hospital.
- 1851 MENDEZ, Sr. D. BARTHOLOME, Madrid.
- 1851 MARINO, Sr. D. BONIFACIO MATEOS, Madrid.
- 1849 MILLIGAN, J., Esq. (FM 1849), 1, South-street, Keighley, Yorkshire.
- 1851 MOLINA, Sr. D. M. M., Madrid.
MOORE, GEORGE, M.D., M.R.C.P., M.R.C.S. (FM 1834), Hastings. ‡ 2.
NASH, JAMES, M.D., High-street, Worcester, Consulting Physician to the
Worcester Infirmary.
NEFRI, GAETÀNO, M.D., Pisa.
- 1851 ORTEGA, Sr. D. J. R., Madrid.
- 1865 PERUZZI, DOMENICO, M.D., Senigaglia.
- 1851 POETILLA, Sr. D. L. LUIS, Madrid.

Elected

- 1860 ROUSSELL, Dr., Dean of Faculty and Medicine at Montpelier.
SAVERY, JOHN CHARLES, Esq., 12, York Buildings, Hastings.
- 1865 SCANZONI, Professor F. W. VON, Physician to the Lying-in Hospital,
Wurzburg.
SCHARLAU, GUS. W., M.D., Stettin, Prussia.
- 1854 SEATON, JOS., M.D., F.R.C.P. (Edin.), F.R.G.S., Halliford House,
Sunbury. ‡ 5.
- 1851 SESSE, Sr. D. M., Mesqui, Madrid.
STOCKWELL, THOMAS G., Esq., 9, Alfred-street, Bath.
STOLTERFOTH, SIGISMUND, M.D., F.R.C.P., Queen's-park, Chester.
- 1851 TEREZA, Sr. L. FELIX GARCIA, Madrid.
TERRY, H., F.R.C.S., Surgeon Extraordinary, General Infirmary, North-
ampton.
- 1851 VALDEZ, Sr. D. FRANCO CORTIGO, Madrid.
WEBSTER, GEORGE, M.D., Dulwich, S.E. ‡, ||.
WHITING, JOHN, M.D., M.R.C.P., Ramsgate. P.
WILLIAMS, CHARLES, Esq., 9, Prince of Wales-road, Norwich.
WILSON, CHARLES, M.D., Dalrymple Crescent, Grange, Edinburgh.

GENERAL LIST OF FELLOWS OF THE SOCIETY.

EXPLANATIONS OF ABBREVIATIONS.

P.—President.	FM.—Fothergillian Gold Medallist.
VP.—Vice-President.	SM.—Silver Medallist.
T.—Treasurer.	O.—Orator.
L.—Librarian.	§—Secretary Foreign Correspondence.
S.—Secretary.	‡—Steward.
C.—Councillor.	*—Life Members.
LL.—Lettsomian Lecturer.	||—Conversazione Steward.

The number prefixed (*e.g.* 1853) signifies the date of election.

The figures appended (*e.g.* s 2, c 3) indicate the number of Sessions served, and refer to past appointments ONLY.

NS.—Non-subscribing.

Alteration of Law.—Every Fellow residing within the Limits of the London and Suburban postal districts, shall on admission pay one guinea as his entrance fee, and one guinea as his annual subscription; and every Fellow residing beyond the postal and Suburban postal districts shall pay one guinea as his annual subscription, but shall not be required to pay any entrance fee. All Subscribing Fellows shall equally enjoy all the privileges of Fellows.

Elected

- 1874 ACTON, WILLIAM, Esq., Harley-street, W.
 1873 ADAMS, M. A., F.R.C.S., Maidstone, Kent.
 1872 ADAMS, T. RUTHERFORD, M.D., Stamford House, Croydon. ||.
 1852 ADAMS, WILLIAM, F.R.C.S., Surgeon to the Great Northern Hospital, 5, Henrietta-street, Cavendish-square, W. c 6, o 9, ‡ 1, VP 3, ||, LL.
 1868 AITKEN, WM., M.D., F.R.S., Woolston, Southampton. ||. NS.
 1872 ALDRED, HENRY ALLEN, M.D., 7, Albemarle-street. ‡.
 1873 ALEXANDER, REGINALD G., M.B., 13, Hallfield-road, Bradford, Yorkshire.
 1873 ALLEN, H. MARCUS, M.R.C.P. Edin., 38, Regency-square, Brighton.
 1873 ALLFREY, C. H., M.D., St. Mary's Cray, Kent. ||.

Elected

- 1872 ALLINGHAM, WILLIAM, F.R.C.S., 10, Chandos-steeet, Cavendish-square, Surgeon to St. Mark's Hospital for Diseases of the Rectum. ‡.
- 1860 ALTHAUS, JULIUS, M.D., 18, Bryanston-street, Portman-square, W., Senior Physician to the Infirmary for Epilepsy and Paralysis. c 5, ‡ 1, §.
- 1871 AMBLER, VINCENT, F.F.P.S. Glas., 14, Colville-square, Bayswater, W., Surgeon Major, 1st Surrey R.A.V. 3, ||.
- 1869 ANGUS, JOHN, Esq., Medical Officer to the Strand Union Infirmary, 66, Frith-street, Soho, W.
- 1861 ANSTIE, F. E., M.D., F.R.C.P., 16, Wimpole-street, W., Physician and Lecturer on Medicine, Westminster Hospital, &c. c. 4, LL 2, ‡ (*Orator*).
- 1869 ARMITAGE, S. H., M.D., Huntriss-row, Scarboro'. NS.
- 1868 ARMSTRONG, JOHN, M.D., Dartford. NS.
- 1868 ARMSTRONG, JOHN CHRISTOPHER, Esq., Gravesend. NS.
- 1873 ARNOLD, HOWARD, Esq., 10, Lower-Crescent, Belfast. NS.
- 1871 ARNOLD, WILBERFORCE, Esq., Belfast. NS.
- 1867 ASPRAY, CHARLES OWEN, M.D., F.R.C.S., Senior Surgeon to St. George's and St. James's Dispensary, 4, Devonshire-street, Portland-place, W.
- 1873 ATKINSON, EDWARD, Esq., F.L.S., 2, Albion-place, Leeds, Senior Surgeon to Leeds Public Dispensary.
- 1872 AVELING, JAMES H., M.D., 1, Upper Wimpole-street, W., Physician to the Chelsea Hospital for Women. ‡.
- 1873 BAGSHAW, FREDERIC, M.A., M.D., 5, Warrior-square, St. Leonards. ‡.
- 1871 BAILEY, GEORGE H., Esq., 25, Charles-street, Middlesex Hospital, W. ‡.
- 1873 BAILEY, JAMES J., Esq., Stockport.
- 1868 BARDSLEY, SIR JAMES LOMAX, Kt., M.D., F.R.C.P., Greenheys, near Manchester. ‡. NS.
- 1859 BARNES, J. WICKHAM, F.R.C.S., 136, Gower-street, Bedford-square. ‡ 5, c 3, s 2, ||.
- 1871 BARRY, D. PATERSON, M.D., Twickenham. NS.
- 1874 BARRETT, HOWARD, Esq., 3, Tavistock-square, W.C.
- 1868 BATEMAN, FREDERIC, M.D., Upper St. Giles-street, Norwich. NS.
- 1868 BEATTY, THOMAS CARLYLE, Esq., Seaham, Sunderland. NS.
- 1868 BELL, The REV. DAVID, M.D., C.M., The Vicarage, Goole, Yorkshire. ||.
- 1867 BELL, H. ROYES, F.R.C.S. Exam., 44, Harley-street, W., Assistant-Surgeon to King's College Hospital. || 4, ‡ 5, c 3 (*Vice-President*), s, SM.
- 1872 BELL, JOHN H., M.D., Northampton. NS.
- 1868 BENNETT, JOHN HUGHES, M.D., F.R.C.P., F.R.S., Edinburgh. NS.
- 1872 BERKART, I. B., M.D., Bryanstone-street, Portman-square, W., Assistant-Physician to the City of London Hospital for Diseases of the Chest.
- 1873 BEVERIDGE, J. SPOWART, M.R.C.P. Ed., 4, Brunswick-ter., Kensington, W.
- 1868 BIRD, GEO., M.D., 49, Welbeck-street.
- 1850 *BIRKETT, JOHN, F.R.C.S., 59, Green-st., Grosvenor-sq., W., Surgeon to, and Lecturer on Surgery at, Guy's Hospital. VP, c 6, ‡ 2, ||.

Elected

- 1868 BLOWER, WILLIAM, Esq., Bedford. NS.
- 1871 BLOXAM, JOHN ASTLEY, F.R.C.S., 8, George-street, Hanover-square, W.,
Assistant Surgeon to the Charing Cross and West London Hospitals.
||, ‡.
- 1868 BLOXAM, WILLIAM, M.D., 21, Mount-street, W. || 2, ‡, c 2.
- 1867 BOND, THOMAS, M.B., B.S., F.R.C.S., 50, Parliament-street, S.W.
- 1864 BONNEY, F. A. BURDETT, Esq., Elm House Asylum, 149, Church-street,
Chelsea, S.W. ‡ 2, || 2.
- 1871 BOTHWELL, G. G., Esq., 227, Burrage-road, Plumstead. NS.
- 1868 BOULTON, B. J., M.D., Horncastle. NS.
- 1872 BOULTON, PERCY, M.D. Ed., 6, Seymour-street, Portman-square, W.,
Physician to the Samaritan Hospital.
- 1868 BRADY, JOHN, M.P., Ely, Cambs.
- 1868 BRAIDWOOD, P. M., M.D., Birkenhead. NS.
- 1869 BRAINE, WOODHOUSE, F.R.C.S., 56, Maddox-street, W. c, || 4 (*Hon. Sec.*),
‡ 4.
- 1871 BOYD, ROBERT, M.D., F.R.C.P., 1, Bolton-row, W. ‡ 2.
- 1873 BRIDGWATER, THOMAS, M.B., Medical Officer of the Harrow Dispensary.
‡.
- 1863 BROADBENT, W. H., M.D., F.R.C.P., 34, Seymour-street, Portman-square,
W., Physician to St. Mary's and London Fever Hospitals; Lecturer on
Medicine St. Mary's Hospital Medical School. ‡ 2, c 4, || 4
(*Vice-President*), LL.
- 1871 BROWN, JOHN, Esq., 2, Rose-villas, Falcon-road, Clapham Junction, S.W.,
Medical Officer Battersea Dispensary.
- 1874 BROWN, JAMES DAWES, F.R.C.S., Haverfordwest, Surgeon to the
Infirmary.
- 1871 BROWNE, J. CRICHTON, M.D., Wakefield. NS.
- 1873 BROWNE, LENNOX, Esq., 14, Weymouth-street, W., Surgeon to the Royal
Society of Musicians. ‡ 2, ||.
- 1873 BRUNJES, MARTIN, Esq., 42, Brook-street, Grosvenor-square, W. ‡.
- 1862 BRUNTON, JOHN, M.A., M.D., Surgeon to Royal Maternity Charity,
21, Euston-road, N.W. ‡ 4, || 4 (*Councillor*).
- 1850 BRYANT, THOMAS, F.R.C.S., 53, Upper Brook-street, W., Surgeon to Guy's
Hospital. (*Councillor*), P, VP 2, S 2, c 4, LL, ‡ 9, || 2.
- 1848 BRYANT, WALTER J., F.R.C.S., 23A, Sussex-square, Hyde-park-gardens,
W. || 2.
- 1858 BUCHANAN, GEORGE, M.D., F.R.C.P., 24, Nottingham-place, Regent's-
park, Assistant Medical Officer to the Local Government Board.
c 2, LL, VP 2, ‡, || 2.
- 1868 BUCKLE, FLEETWOOD, M.D., H.M.S. *Orontes*. NS.
- 1873 BUNNY, JOSEPH, M.D., Newbury, Berks., Coroner for Boro'.
- 1872 BURGER, ALEX., Esq., 6, King-street, Finsbury.
- 1850 BURNIE, WM., M.D., Bradford. (*Transferred 1871.*) ||. NS.
- 1874 BURNES, ALEX. GEO., M.B., C.M., 50, Green-street, Grosvenor-square, W.

Elected

- 1868 BURROWS, SIR JOHN CORDY, F.R.C.S., Brighton. NS.
- 1872 BYAS, EDWARD H., Esq., 25, Belsize-park, Hampstead, N.W., and Grove Hall, Bow, E.
- 1867 CALTHROP, EDWARD, L.R.C.P., 2, Shaftesbury-villas, Hornsey-rise, N. ||.
- 1850 CAMPS, WM., M.D., Western-villas, Ealing. c 5, ‡ 17.
- 1839 CANTON, EDWIN, F.R.C.S. (FM 1857), 30, Montague-place, Russell-square, W.C., Surgeon and Lecturer on Surgery at Charing-cross Hospital; Surgeon to the British Museum. P, VP 2, c 6, LL, s, o, ‡ 12, ||.
- 1870 CARPENTER, ALFRED, M.D., High-street, Croydon. || (*Councillor*).
- 1873 CARR, WILLIAM, M.D., Lee-grove, Blackheath.
- 1871 CARTER, R. BRUDENELL, F.R.C.S. (Exam.), 69, Wimpole-street, W., Surgeon Royal South London Ophthalmic Hospital; Ophthalmic Surgeon to, and Lecturer on Ophthalmic Surgery at, St. George's Hospital. o 3, ‡ 2, || (*Councillor*).
1848. CARTWRIGHT, S., F.R.C.S., 32, Old Burlington-street, W., Professor of Dental Surgery and Surgeon Dentist to King's College Hospital, London; Consulting Surgeon to the Dental Hospital of London. ‡ 9.
- 1865 CHAMBERS, THOS., M.R.C.P. Ed., F.R.C.S., 2, Bolton-row, Mayfair, and 2A, Sutherland-street, S.W., Physician to the Chelsea Hospital for Women, and Consulting Physician Accoucheur to the Western Dispensary, Westminster. ||.
- 1867 CHAPMAN, JOHN, M.D., 25, Somerset-street, Physician to the Farringdon Dispensary. ‡ 2.
- 1872 CHARLSLEY, W. P., M.D., Inspector General of Hospitals, Island of Ceylon. NS.
- 1868 CHESSALL, WILLIAM, M.D., Horley, Surrey. NS.
- 1868 CHILD, EDWIN, Esq., New Malden and Coombe, Surrey. ‡ 4, ||. NS.
- 1861 CHOLMELEY, W., M.D., F.R.C.P., 63, Grosvenor-street, W., Physician to the Great Northern Hospital, and to the Margaret-street Infirmary for Consumption; *Hon. Sec. for Foreign Corr.* c 5, ‡ 8, SM, o, || 3, VP.
- 1870 CHRISTIE, T. B., M.D., F.R.C.P., Royal India Asylum, Ealing, W. ||.
- 1871 CHURTON, THOMAS, Esq., Pier-road, Erith, S.E. ||, ‡.
- 1874 CLAPTON, W., F.R.C.S., 42, Bloomsbury-square, W., Surgeon to West City Dispensary and Royal Humane Society.
- 1854 CLARK, ANDREW, M.D., F.R.C.P., 16, Cavendish-Square, W., Physician to, and Lecturer on Clinical Medicine at, the London Hospital; Consulting Physician to the East London Hospital for Children. P, VP, c 5, LL, ‡ 5, || 4.
- 1837 CLARKE, J. F., Esq., 23, Gerrard-street, Soho, W. VP 3, c 15, o, s 6, ‡ 7.

Elected

- 1873 CLARKE, T. KILNER, M.A., M.B., Huddersfield.
- 1870 CLOUSTON, T. F., M.D. (FM 1870), Superintendent Royal Asylum, Edinburgh. NS.
- 1873 CLUBBE, W. H., Esq., Lowestoft.
- 1869 COATES, WILLIAM MARTIN, Esq., Salisbury, Surgeon Salisbury Infirmary. NS.
- 1849 COCKLE, JOHN, M.A., M.D., F.R.C.P., 7, Suffolk-place, W., and West Moulsey Lodge, Surrey, Physician to the Royal Free Hospital. VP, c 2, L 3, ‡ 5, SM, ||, O.
- 1848 COGSWELL, C., M.D., 47, York-terrace, Regent's-park, W.C. s 4, ‡ 7, || (*Trustee*).
- 1867 COLES, GEORGE CHARLES, Esq., 20, Great Coram-street, Russell-square, W.C., Surgeon to the Infirmary for Epilepsy and Paralysis, and Assistant-Surgeon to the Royal South London Ophthalmic Hospital. ‡ 6, || 3.
- 1872 COLES, J. OAKLEY, Esq., L.D.S., R.C.S., 81, Wimpole-street, W. ‡.
- 1853 COLLAMBELL, C., F.R.C.S., 15, Lambeth-terrace, Lambeth, S. ‡ 2, || 2.
- 1870 COLLIE, ALEXANDER, M.D., Resident Medical Officer to the Fever Hospital, Homerton, E.
- 1871 COOK, JOHN, M.D., 3, Upper Wimpole-street, W., Senior Physician to St. Marylebone General Dispensary.
- 1863 COOPER, ALFRED, F.R.C.S., 9, Henrietta-street, Cavendish-square, W., Surgeon to the West London Hospital, and to (Out-patients) Lock Hospital; Assistant-Surgeon to St. Mark's Hospital for Fistula. || 2, c 3, ‡ 5 (*Councillor*).
- 1873 COOPER, SIR HENRY, M.D., F.R.C.P., 9, Charlotte-street, Hull, Senior Physician to the Hull General Infirmary.
- 1872 CORFIELD, W. H., M.A., M.D., 8, Bolton-row, Professor of Hygiene, &c., University College Hospital; Medical Officer for Health to St. George's, Hanover-square. ||, ‡.
- 1851 *COTTON, R. PAYNE, M.D., F.R.C.P. (FM 1851), 33, Cavendish-square, W., Senior Physician to the Hospital for Consumption and Diseases of the Chest, Brompton. c 3, ‡ 2.
- 1861 COULSON, WALTER J., F.R.C.S., 29, St. James's-place, S.W., Surgeon to the Lock Hospital and St. Peter's Hospital for Stone. s 2, c 3, ‡ 6.
- 1849 COULSON, WILLIAM, F.R.C.S., Hon. Fellow, *q.v.*
- 1873 CRAVEN, R. MARTIN, Esq., 14, Albion-street, Hull.
- 1871 CRISP, EDWARDS, M.D., 29, Beaufort-street, Chelsea, S.W. SM 1845, FM 1872, c, || 2, ‡ 2.
- 1872 CROMBIE, JOHN, M., M.A., M.B., House Surgeon to Cancer Hospital, Brompton, S.W.
- 1855 CROSS, R., M.D., F.R.C.P. Edin., 42, Craven-street, Strand, W.
- 1874 CUMBERBATCH, A. E., M.B., F.R.C.S., 8, Upper Brook-street, W. ||.

Elected

- 1871 DALBY, WM. BARTLETT, M.B. Cantab., F.R.C.S., 8, Savile-row, W.,
Aural Surgeon and Lecturer on Aural Surgery at St. George's
Hospital.
- 1865 DALE, G. C., M.D., F.R.C.S., 1, Ledbury-road, W. ||.
- 1873 DALY, OWEN, M.D., F.R.C.S., 25, Albion-street, Hull.
- 1868 DANIEL, WILLIAM COLE, Esq., Stony Stratford. ns.
- 1831 *DAVIDSON, THOMAS, M.D., Shaftesbury House, Bayswater, W. vp 2, c 5,
|| 20, sm, ‡, §.
- 1868 DAVY, RICHARD, F.R.C.S., 33, Welbeck-street, W., Surgeon and Lecturer
on Anatomy at the Westminster Hospital. ‡ 2.
- 1871 DAY, HENRY, M.D., F.R.C.P., Stafford. ns.
- 1867 DAY, WM. HENRY, M.D., 10, Manchester-square, Physician to the Sama-
ritan Free Hospital for Women and Children. || 4, ‡ 5.
- 1873 DAWES, RICHARD ST. MARK, Esq., 1, Portsdown-road, W.
- 1870 DEMPSEY, JOSEPH M., M.D., 27, Charter-house-square, E.C.
- 1871 DE RENZY, A. O. C., Esq., Lahore. ns.
- 1844 *DIAMOND, HUGH W., M.D., Twickenham House, Twickenham, Mid-
dlesex. ‡ 2.
- 1858 DIAMOND, WARREN HASTINGS, M.R.C.P. Edin., Brixton, S., Physician
to the Brixton, Streatham, and Herne-hill Dispensary, &c.
- 1868 DICK, HENRY, M.D., 59, Wimpole-street, W., formerly Surgeon to the
National Orthopædic Hospital.
- 1871 DICKENSON, JAMES C., Esq., Surgeon to St. Marylebone General Dis-
pensary.
- 1872 DOWN, J. LANGDON, M.D., F.R.C.P., 39, Welbeck-street, W., and Nor-
mansfield, Hampton Wick, Physician to the London Hospital. ||.
- 1871 DOWSE, THOMAS S., M.D., Central London Sick Asylum, Highgate, N.
- 1848 DUNCAN, JAMES, M.B., 8, Henrietta-street, Covent-garden, W.C. ‡, || 2.
- 1874 DUNCAN, B. ARCEDECKNE, M.R.C.P. Edin., Gower-house, 88, Gower-street,
W.C. ||.
- 1857 DUNN, R. W., Esq., 13, Surrey-street, Strand, W.C. ‡ 6, c 3, || 2.
- 1848 DU PASQUIER, C. F., F.R.C.S., 62, Pall Mall, Surgeon Apothecary to Her
Majesty; Apothecary in Ordinary to Her Majesty's Household; Sur-
geon Apothecary to H.R.H. Prince of Wales' Household, &c. ‡ 2,
||, c 3.
- 1873 DURANTZ, E. NICHOLAS, M.D., Marseilles. ns.
- 1873 DURHAM, A. E., F.R.C.S., 82, Brook-street, W., Surgeon to Guy's Hospital.
- 1872 DUTTON, JAMES, Esq., 2, Theresa-place, Hammersmith.
- 1865 EBSWORTH, ALFRED, F.R.C.S., 11, Collingham-road, South Kensington,
and 9, Henrietta-street, Covent garden, W.C.
- 1860 EDMUNDS, J., M.D., M.R.C.P. Lond., 5, Savile-row, W., Physician to the
London Temperance Hospital. ‡ 5, ||.
- 1868 ELLIOT, GEO. F., M.D., Hull. ns.

Elected

- 1850 ELLIOTT, CYRUS A., Esq., Elm-villa, Broadwater, Worthing, and Munster House, Fulham, S.W.
- 1869 ELLIS, JAMES, M.D., Welling, S.E.
- 1872 ELLIS, JAMES, Esq., Calcutta. NS.
- 1864 EVANS, GEO., Esq., 69, Gloucester-place, W. ‡ 2.
- 1868 EVANS, WILLIAM, M.D., 1, College-terrace, Belsize-park.
-
- 1869 FARQUHARSON, R., M.D., 23, Brook-street, Grosvenor-square, W., Physician to the Belgrave Hospital for Children. || 2, ‡ 2 (*Councillor*).
- 1872 FAYRER, JOSEPH, M.D., C.S.I., F.R.C.P., 16, Granville-place, Portman-square, W. ‡, ||.
- 1847 FIELD, WM., Esq., 224, Oxford-street, W. ‡ 6, ||.
- 1868 FLETCHER, JAMES OGDEN, M.D., F.R.C.S. (Eng.), Manchester. NS.
- 1868 FLETCHER, THOMAS BELL, M.D., F.R.C.P., Senior Physician to the Birmingham General Hospital.
- 1868 FOLKER, WILLIAM HENRY, F.R.C.S., Hanley, Staffordshire.
- 1873 FOSS, R. W., M.D., Stockton-on-Tees, Honorary Medical Officer Stockton Surgical Hospital.
- 1869 FOSTER, BALTHAZAR W., M.D., F.R.C.P., 16, Temple-row, Birmingham. NS.
- 1872 FOTHERGILL, J. MILNER, M.D., 22, Lower Seymour-street, W. ||.
- 1873 FOX, A.W., M.B., 16, Gay-street, Bath, Physician Eastern Dispensary, Bath.
- 1868 FOX, CHARLES HENRY, M.D., Brislington House, near Bristol. NS.
- 1868 FOX, CHARLES JAMES, Esq., M.R.C.S., L.D.S., 27, Mortimer-street, Cavendish-square, W., Dental Surgeon to Great Northern Hospital and Dental Surgeon to Dental Hospital of London. || 4, ‡ 4.
- 1871 FOX, FRANCIS, L.R.C.P., 1, Hamilton-terrace, Ladbroke-grove, Kensington-park, W. || 2.
- 1868 FOX, JOHN, Esq., Norwich. NS.
- 1863 FOX, TILBURY, M.D., F.R.C.P., 14, Harley-street, W., Physician to the Department for Diseases of the Skin University College Hospital. c, ‡ 4, LL.
- 1869 FRAMPTON, THOMAS, L.R.C.P., 62, Gloucester-terrace, Hyde-park. ||.
- 1868 FREER, ALFRED, Esq., Stourbridge. NS.
- 1868 FRY, FRED., F.R.C.S., Maidstone. NS.
-
- 1868 GAINE, CHARLES, Esq., Bath. NS.
- 1862 GANT, F. J., F.R.C.S., 16, Connaught-square, W., Surgeon to the Royal Free Hospital. || 2, ‡ 4, LL, o (*Vice President*), c 2.
- 1849 GARDNER, HARRY, M.D., Westbourne-terrace villa, Westbourne-square, W. c 2.
- 1847 GARROD, ALFRED B., M.D., F.R.C.P., F.R.S., 10, Harley-street, W. P, VP 2, c 9, o, LL, ‡ 2.

Elected

- 1849 GAY, JOHN, F.R.C.S., 10, Finsbury-place, South, E.C., Senior Surgeon to the Great Northern Hospital; Consulting Surgeon to the Idiot Asylum, Earlswood, and to the Metropolitan Railway. D, LL, c 3, o, ‡ 4, P (*Treasurer*), || 3.
- 1873 GEE, ROBERT, M.D., 5, Abercrombie-square, Liverpool.
- 1856 GIBBON, S., A.B., M.B., 11, Finsbury-place, South, E.C., and 39, Oxford-terrace, W. ‡.
- 1873 GILL, JOHN B., M.D., Dover.
- 1867 GILL, WILLIAM, Esq., L.R.C.P. Lond., 43, Woburn-place, W.C. ‡ 2.
- 1871 GLYNN, T. R., M.B., Liverpool. NS.
- 1857 GODFREY, JOHN, M.D., F.R.C.P. Edin., Mount-terrace, E.
- 1869 GODSON, CLEMENT, M.D., 8, Upper Brook-street, Grosvenor-square, W., Physician to the Samaritan Free Hospital for Women and Children ‡, || (*Councillor*).
- 1872 GODSON, CHARLES, F.R.C.S., Barnet, Herts, Medical Officer Barnet Union. ||, ‡. NS.
- 1853 GOLDSBRO, THOMAS W. J., M.D., 40, West-square, Southwark, S.E.
- 1869 GOODMAN, CHAS. ROWLAND, M.D., M.R.C.P., Cheetham, Manchester. NS.
- 1873 GOODSALL, D. H., F.R.C.S., 34, Finsbury-square, E.C., Surgeon to the Free Hospital. ‡.
- 1864 GOSS, S. DAY, M.D., F.R.G.S., 111, Kennington Park-road, S. ‡ 6, c 2, ||, L 4, SM.
- 1867 GRASEMANN, C. EDWARD, M.D., 46, Albany-street, Regent's-park, N.W. || 2.
- 1872 GRAY, ROBERT, Esq., Indian Medical Service. NS.
- 1843 *GREENHALGH, ROBERT, M.D., 72, Grosvenor-street, W., Physician Accoucheur and Lecturer on Midwifery and the Diseases of Women and Children, St. Bartholomew's Hospital; Consulting Physician to the City of London Lying-in and Samaritan Hospitals, &c. &c. P, VP, o, c 5, s 3, ‡ 4.
- 1868 GREGSON, GEO., Esq., 26, Harley street, Dental Surgeon to the Dental Hospital of London and to the Metropolitan Free Hospital. ‡ 3, || 3.
- 1873 GRIEVE, ROBERT, M.D., Crouch End, Hornsey, N.
- 1868 GRIFFITH, THOMAS TAYLOR, F.R.C.S. (Eng.), Wrexham. NS.
- 1874 GRIFFITH, R. GLYN, Esq., Bangor, Surgeon to the Carnarvonshire and Anglesey Infirmary.
- 1873 GRINDROD, R. B., M.D., Townsend House, Great Malvern.
- 1859 HABERSHON, S. O., M.D., F.R.C.P., 70, Brook-street, Senior Physician to, and Lecturer on the Practice of Medicine at, Guy's Hospital. P, c 3, o, ‡ 4, || (*Councillor*), LL.
- 1869 HADEN, W. H., M.D., 66, Harley-street. ||, ‡.
- 1868 HAINWORTH, JOHN, F.R.C.S., 138, Camden-road, N.W. || 3 (*Councillor*), ‡.
- 1851 *HALLEY, ALEXANDER, M.D., 16, Harley-street, W.

Elected

- 1871 HAMILTON, ROBERT, M.D. Cantab., 1, Howick-place, Victoria-street, S.W. ||, ‡.
- 1834 HARDING, WM., Esq., 4, Percy-street, Bedford-square, W.C. VP 2, c 3, ‡ 5, ||.
- 1855 HARDINGE, H., M.D., 18, Grafton-street, Bond-street, W., Physician to the Great Northern Hospital, &c. c 2, ||.
- 1873 HARDWICK, JUNIUS, F.R.C.S., Rotherham, Yorks.
- 1872 HARDY, HORATIO N., F.R.C.S. Edin., 21, Fitzroy-square, W., Surgeon City of London and East London Dispensary. || 2.
- 1850 *HARE, CHARLES J., M.D., F.R.C.P., Hon. Fellow, *q.v.* || (*Trustee*).
- 1865 HARPER, PHILIP, F.R.C.S., 30, Cambridge-street, Hyde-park, W. ‡.
- 1873 HARLEY, EDWARD, L.R.C.P., Saffron Walden, Surgeon to Saffron Walden Hospital.
- 1871 HARRIS, CHARLES JAMES, Esq., 11, Kilburn Priory, N.W. ||.
- 1872 HARRIS, HENRY, M.D., Trengweath, Redruth, Cornwall. ||. ns.
- 1873 HARRIS, WM. JOHN, Esq., 13, Marine Parade, Worthing. ||, ‡.
- 1851 HARRISON, C. H. ROGERS, F.R.C.S., Vine House, Stockwell-road, S., Consulting Surgeon to St. Pancras Infirmary; Honorary Surgeon to Brixton and Stockwell Dispensary. VP 2, c 3, s 5, T 6, SM, ‡ 20, || (*Trustee*).
- 1871 HARRISON, REGINALD, F.R.C.S., Liverpool, Lecturer on Surgery at the Royal School of Medicine. ns.
- 1865 HARVEY, J. A., Esq., 35, Princes-square, Bayswater, W.
- 1847 HARVEY, WM., F.R.C.S., 2, Soho-square, W., Surgeon to the Royal Dispensary for Disease of the Ear; Aural Surgeon Great Northern Hospital, &c. c 10, ‡ 7, ||.
- 1852 HAWARD, EDWIN, M.D., 83, Wimpole-street, W. ‡ 2.
- 1852 HAWSKLEY, THOMAS, M.D., 6, Brook-street, Grosvenor-square, W., Consulting Physician to the Margaret-street Infirmary for Consumption. c 5, ‡ 2, ||.
- 1872 HAZEL, GEORGE, Esq., 71, Oakley-square, N.W. ||, ‡.
- 1862 HEAD, EDWARD, M.B., F.L.S., Obstetric Physician to the London Hospital, and Lecturer on Midwifery and the Diseases of Women at the London Hospital Medical School, &c. c, L, ‡ 3.
- 1873 HEARD, R. LYNN, Esq., Barrington Lodge, Cold Harbour-lane, Brixton, S.
- 1869 HEATON, JOHN DEAKIN, M.D., F.R.C.P., Leeds. || 2.
- 1871 HEMMING, W. B., Esq., 26, Notting-hill-terrace, W., Consulting Surgeon Notting-hill and Shepherd's-bush Dispensary. ‡, ||.
- 1853 HENRY, A., M.D., 16, Brunswick-square, W.C. c 7, ‡ 4.
- 1872 HICKS, JOHN BRAXTON, M.D., F.R.C.P., F.R.S., 24, George-street, Hanover-square, Physician-Accoucheur and Lecturer on Midwifery and Diseases of Women and Children, Guy's Hospital. ||, ‡.
- 1870 HILL, JNO. DANIEL, F.R.C.S. (Exam.), 17, Guildford-street, W.C., Surgeon to the Royal Free Hospital; Surgeon to the Royal Orthopædic Hospital. || 2, ‡ 2, c, ||.

Elected

- 1868 HILL, R. GARDNER, L.R.C.P., &c., Res.-Phys., Earl's Court House, Old Brompton. s 2, ‡, ||.
- 1867 HILL, THOS. HARVEY, Esq., 4, Stanhope-terrace, Bayswater. ‡ 6, || 4 (*Councillor*).
- 1845 *HILTON, JOHN, F.R.S., F.R.C.S., Hon. Fellow, *q. v.* p, VP, c 3, ‡ 2, SM.
- 1840 HIRD, FRANCIS, F.R.C.S., 13, Old Burlington-street, W., Surgeon to Charing-cross Hospital. p 2, VP 6, c 12, LL, o 2, ‡ 20 (*Trustee*).
- 1873 HOBSON, W. H., Esq., Great Berkhamstead, Herts, Honorary Surgeon West Herts Infirmary.
- 1873 HODGE, B. TERRY, L.R.C.P., Sidmouth, Devon.
- 1848 HOGG, JABEZ, Esq., 1, Bedford-square, W.C., Surgeon to the Royal Westminster Ophthalmic Hospital. VP, c 2, ‡ 8, || 2.
- 1868 HOLMAN, CONSTANTINE, M.D., Reigate. ‡, || (*Councillor*).
- 1873 HOOPER, ALFRED, F.R.C.S., 24, The Chase-common, Clapham.
- 1865 HUME, F. H., Esq., 58, Devonshire-street, Islington, N. ‡.
- 1833 HUTCHINSON, F., F.R.C.S., M.D., 29, Woburn-place, Russell-square, W.C. c 13, ‡ 9.
- 1869 IRWIN, W. C., Esq., Leicester. NS.
- 1868 JACKSON, J. HUGHLINGS, M.D., F.R.C.P., 3, Manchester-square, W., Physician to the London Hospital and to the Hospital for Epilepsy and Paralysis. (*Councillor*).
- 1853 JACKSON, R., M.D. (Edin.), 53, Notting-hill-square, W., Consulting Surgeon Notting-hill and Shepherd's-bush Dispensary.
- 1871 JACKSON, T. CARR, F.R.C.S., 91, Harley-street, W., Surgeon to the Great Northern Hospital, and to the National Orthopædic Hospital. ||.
- 1868 JAMES, M. PROSSER, M.D., 29, Albemarle-street, W., Lecturer on Materia Medica and Therapeutics, London Hospital; Physician to the Hospital for Diseases of the Throat. ‡.
- 1856 JEPHSON, J. H., M.D., Castlenau, Barnes, Physician to the Great Northern Hospital. c 2, ‡ 4.
- 1873 JOHNSON, J. S., Esq., High-street, Croydon, Surgeon to the Croydon Dispensary.
- 1873 JOHNSTON, JAS., M.B., 9, Easy-row, Birmingham, Physician to the Queen's and Children's Hospitals, Birmingham.
- 1868 JOHNSON, RICHARD L., L.R.C.P. Edin., L.R.C.S., 6, Bedford-street, Bedford-square, W.C. ||.
- 1874 KEENE, JAMES, F.R.C.S., 33, Maddox-street, W., Assistant-Surgeon to the Westminster and Central London Ophthalmic Hospitals.
- 1847 KELLOCK, W. BERRY, Esq., Stamford-hill, N. || 2, ‡.
- 1873 KEMP THORNE, JOHN, F.R.C.S., Callington, Cornwall.
- 1866 KING, KELBURN, M.D., Hull. NS.

Elected

- 1868 KIRKMAN, WM. P., M.D., Barming-Heath, Maidstone. ||, ‡. NS.
- 1860 KITCHING, JOHN, M.D., The Retreat, York. NS.
- 1868 KNAGGS, SAMUEL, Esq., Huddersfield. ‡. NS.
-
- 1868 LAKE, W. C., M.D., Teignmouth, Devon. ‡, ||. NS.
- 1872 LAWRENCE, H. CRIPPS, L.R.C.P., 158, Queen's-road, Bayswater.
- 1858 LAWSON, GEORGE, F.R.C.S., 12, Harley-street, W., Surgeon to the Royal London Ophthalmic Hospital, and Surgeon to the Middlesex Hospital: VP 2, c 3, ‡ 4.
- 1873 LAWSON, HENRY, M.D., 10, George-street, Hanover-square, Assistant-Physician to St. Mary's Hospital.
- 1853 LEARED, ARTHUR, M.D., F.R.C.P., 12, Old Burlington-street, W., Senior Physician to the Great Northern Hospital. c 3, o, ‡ 5, || 2.
- 1869 LEE, C. A., M.D., Surgeon, R.N. NS.
- 1852 LEE, HENRY, F.R.C.S., 9, Saville-row, W., Surgeon to St. George's Hospital. VP 2, c 4, ‡ 6, LL.
- 1873 LEE, R. J., M.A., M.D., 4, Savile-row, W., Assistant-Physician-Accoucheur to St. George's Hospital; Assistant-Physician to the Hospital for Sick Children. ‡.
- 1873 LEEDS, EDWARDS, M.A., M.B., Wicker Sheffield, Lecturer on Physiology Sheffield School of Medicine.
- 1858 LEMON, OLIVER, Esq., Langley-hill House, Kings Langley, Herts. ||.
- 1867 LICHTENBERG, GEORGE, M.D., 47, Finsbury-square, Surgeon to the German Hospital. || 2, ‡.
- 1869 LIPSCOMB, JOHN T. N., M.D., St. Albans, Herts. NS.
- 1868 LITTLETON, THOMAS, M.B. (Lond.), Plymouth. ||. N.S.
- 1870 LLOYD, RIDGWAY R. C. C., Esq., St. Albans. NS.
- 1873 LOE, J. S., Esq., Woodhouse-lane, Leeds. ||, ‡.
- 1868 LOWE, JOHN, M.D. (Edin.), King's Lynn. NS.
- 1868 LUND, EDWARD, F.R.C.S., Manchester. NS.
- 1869 LUNN, WM. JOSHUA, M.D., Hull. NS.
-
- 1871 MACCORMAC, WILLIAM, M.A., F.R.C.S., 13, Harley-street, W., Surgeon and Joint Lecturer on Surgery at St. Thomas's Hospital. ||, ‡.
- 1862 MACKENZIE, MORELL, M.D., 13, Weymouth-street, W., Physician to the Hospital for Diseases of the Throat. ‡ 2, ||.
- 1868 MACKINDER, DRAPER, M.D., Gainsborough. NS.
- 1861 MACLAREN, A. C., Esq., 60, Harley-street, W. || 2, ‡ 3.
- 1865 MACPHERSON, J., M.A., M.D., 35, Curzon-street, Mayfair, W., Inspector-General of Hospitals, H.M. Bengal Army (Retired). || 3, ‡ 2.
- 1869 MADDEN, CHRISTOPHER, M.D., 95, Maida-vale, W.
- 1869 MAGILL, M., M.D., Surgeon R.N. ‡. NS.

Elected

- 1873 MANSFIELD, PIERCE, M.D. R.N., H.M.S. *Egmont*, Rio Janeiro.
- 1868 MARSH, JOHN C. LORY, M.D., Greenhithe, Kent. ns.
- 1873 MARSHALL, EDWARD, Esq., Mitcham, Surrey, Medical Officer to the Mitcham Dispensary.
- 1869 MARSHALL, JAMES, M.D., Aberdeen. ns.
- 1844 MARSHALL, PETER, F.R.C.S., 43, Bedford-square, W.C. p, vp, t, c 7, ‡ 13, sm, ||.
- 1869 MARSHALL, WILLIAM, M.D., Mortlake, Surrey.
- 1865 MARSHALL, W. G., F.R.C.S., Asylum, Colney Hatch, Middlesex. || 2, ‡ 3.
- 1837 MARSON, J. F., F.R.C.S., Resident Surgeon, Small-pox Hospital, N. vp 2, c 8, ‡ 7.
- 1873 MARTIN, ADAM RAE, Esq., Rochester, Surgeon to St. Bartholomew's Hospital, Rochester. ‡.
- 1868 MARTIN, WILLIAM, F.R.C.S., Oriental Club, Hanover-square. || 4.
- 1871 MARTLAND, W., Esq., Blackburn. ns.
- 1862 MASON, FRANCIS, F.R.C.S. (Exam.), 5, Brook-street, Grosvenor-square, Senior Assistant Surgeon to St. Thomas's Hospital. c 4, ‡ 5, sm, o, s 2, || 4 (*Councillor*).
- 1869 MATHEWS, ROBERT, Esq., Bickley, Kent. ||. ns.
- 1873 MAUL, E. H., M.D., Southampton, Physician to the Royal Hants Infirmary.
- 1859 *MAUNDER, C. F., F.R.C.S., 16, Queen Anne-street, Surgeon and Demonstrator of Operative Surgery, London Hospital. || (*Lettsomian Lecturer*).
- 1871 MAURICE, OLIVER C., Esq., Reading. ns.
- 1851 MAY, W. COSTALL, Esq., 52, Tregunter-road, South Kensington, and 27, Bow-Lane, E.C., Hon. Surg. to Vintry Ward Schools, and Surgeon to the Royal Humane Society. ‡ 4, || 2.
- 1862 MAYBURY, A. K., Esq., Richmond, Surrey. ns.
- 1869 McDONAGH, JAMES A., F.R.C.S., Mornington Villa, 211, Hampstead-road, N.W. ||.
- 1873 McHARDY, MALCOLM M., Esq., 34, Stanley-street, S.W.
- 1868 McINTYRE, J., M.D., Odiham, Hants. ns.
- 1865 McOSCAR, JOHN, M.D., 4, Argyll-street, Regent-street, W. ‡.
- 1866 MEREDYTH, COLOMIATI, A. W. L., M.D., 76, Margaret-street, Cavendish-square, W.C.
- 1873 MÉRIC, HENRY DE, Esq., 52, Brook-street, W.
- 1850 MÉRIC, VICTOR DE, F.R.C.S. (Exam.), 52, Brook-street, Grosvenor-square, W., Surgeon to the Royal Free Hospital, and to the German Hospital, Dalston. c 8, ll, o, || 2, ‡ 11, v.p. (*President*).
- 1873 MERRYWEATHER, HENRY, M.D., 17, Howard-street, Sheffield, Lecturer on Dental Surgery, Sheffield School of Medicine.
- 1865 MIDDLEMIST, R. P., Esq., Surgeon to the Westminster General Dispensary, 10, Bedford-place, Russell-square, W.C. ‡, || 2 (*Councillor*).
- 1833 MIDDLETON, JAMES, Esq., 40, Watling-st., E.C., Surgeon Accoucheur to the Finsbury Lying-in Institution. c 10, ‡ 5.

Elected

- 1858 MILLAR, JOHN, Esq., Medical Superintendent, Bethnal House Asylum, N.E. ‡ 8, || 2.
- 1859 MILLER, WILLIAM, Esq., 4, Duke-street, St. James', S.W. ‡ 4.
- 1860 *MONTEFIORE, N., F.R.C.S., 36, Hyde-park-gardens, W. ‡ 2, || 4.
- 1869 MOORE, RALPH, M.D. NS.
- 1871 MORLEY, ALEXANDER, Esq., 42, Albemarle-street, W. || 3.
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- 1872 WILLIAMS, A. WYNN, M.D., 1, Montagu-square, W., Physician to the
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- 1870 WILLIAMS, D. W., M.D., Bury St. Edmunds. NS.
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- 1870 ZIFFO, JEAN E., Constantinople. NS.

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PROCEEDINGS
OF THE
MEDICAL SOCIETY OF LONDON.

October 21st, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

THE hundredth session of the Society was opened with a few introductory practical remarks from the President.

Mr. FRANCIS MASON showed a patient upon whom he had four years ago operated for

UNUNITED FRACTURE OF BOTH BONES OF THE
LEFT FOREARM.

The patient had, two years previous to the operation, sustained a severe compound fracture. The arm was perfectly useless, and the question of amputation was seriously entertained. Mr. Mason briefly described his method of securing the fragments, which consisted in transfixing them with a needle, and taking a loop of wire, either simply or in the form of a figure of eight, round the needle, the ends of the wire and one end of the needle being made to emerge from the same aperture in the skin. Mr. Mason explained that by withdrawing the needle the loop of wire was released, and could be removed at pleasure with the greatest facility. The bones were firmly united, the patient being able to grasp well. She stated that she could perform her ordinary domestic duties most satisfactorily.

The PRESIDENT asked, whether the arm had been immovably fixed? He thought perfect union was often secured even after the lapse of years when perfect fixity was secured.

The PRESIDENT then brought forward a case of

ROSE-COLOURED ERUPTION AFTER THE USE OF CHLORAL,

which occurred to a boy, aged nineteen, who was attacked with tetanus on the nineteenth day after his admission into Guy's Hospital with fracture of the great toe, for which twenty grains of the hydrate of chloral were given every four hours. The rubeoloid eruption appeared on the seventh day, and was general over the face and body; it lasted three days, and disappeared when the chloral was given up. The tetanus however becoming worse, chloral was again given, and the eruption again appeared; it continued also during the use of the drug. The boy ultimately recovered. The President stated that he had seen the same eruption in other cases in which chloral had been given.

Dr. WILTSHIRE doubted whether the hypnotic action of chloral could be due to the evolution of chloroform from decomposition by alkali in the blood, seeing that the amount of chloroform so derived must be very small.

The second case brought forward by the PRESIDENT was that of

A TUMOUR IN THE SOFT PALATE,

which had been growing for eight years, and had produced great difficulty of breathing. The patient was thirty-eight years old, and the tumour was thought not to be cancerous. When under the influence of chloroform the patient was nearly suffocated from the tumour falling upon the rima glottis. As a consequence tracheotomy was performed, and Dr. Trendelenburg's valuable trachea plug and canula inserted. This prevented blood running down the trachea. The patient recovered completely and with great rapidity. The tumour was of a fibro-plastic character.

Mr. WM. ADAMS thought the case a very successful one. An account of a similar one in which he had operated, using a gouge, was reported in the 'Transactions' of the Pathological Society.

Dr. HESSE, of Leipsig, said he had seen Dr. Trendelenburg's instrument advantageously used in Berlin.

Mr. MACCORMAC said the instrument had been used in Germany,

and Dr. Schönbrun, of Königsberg, stated to him that it was a great comfort to surgeons when operating on the mouth or jaw. He asked, what extra risk was caused by the additional operation of tracheotomy? He thought it should be great to counterbalance its great advantages.

Dr. VEIEL, of Stuttgart, had seen this instrument used last winter in Berlin by Langenbeck for an operation on the tongue. Dr. Langenbeck, at a congress of German surgeons, stated that he thought the operation of tracheotomy almost devoid of risk.

The PRESIDENT thought the consideration of tracheotomy should not be dissociated from the disease necessitating it. In the case he had brought forward, it was rather to be regarded as a simple incision.

Dr. WILTSHIRE brought forward a case of

SO-CALLED UTERINE HYDATIDS,

the true nature of which, he explained, consisted in moniliform enlargements of the villi of an imperfectly developed chorion or placenta. He had seen the case in consultation with Dr. Ayling. The patient was in a typhoid condition, with a quick pulse and a high temperature. There had been great loss of blood and offensive discharge for weeks. More than a quart of diseased chorion villi were removed, and the patient made a good recovery. The disease was not due to a parasite but to a degeneration of the chorion villi, a good name for which was "vesicular mole." The significance of hardening in uterine tumours was pointed out in connection with the diagnosis of uterine enlargements.

Dr. GREENHALGH agreed with Dr. Wiltshire's observations, and said he had only seen five cases. They were of a very puzzling character, and the name proposed by Sir James Paget, viz. vesicular mole, was most appropriate. He considered, with Dr. Wiltshire, that hardening of the tumour was significant of its uterine character.

Mr. PETER MARSHALL thought great credit was due to Dr. Wiltshire for his diagnosis of this case, and said he had noticed a rancid taste in the mouth in two cases he had seen.

The PRESIDENT mentioned a case in which true hydatids had been discharged from the uterus "per vaginam." It was in a patient from whom he had some years previously removed a breast for cystic disease of the gland.

Dr. GODSON mentioned a case of vesicular mole which occurred in St. Bartholomew's Hospital; the patient ultimately died.

Dr. BLOXAM asked whether there was vomiting in Mr. Bryant's case, which was answered affirmatively.

The PRESIDENT showed sections of stones which he had removed by lithotomy. One showed a stone within a stone; the others were four in number, and coexisted without facetting or any evidence of friction.

Dr. THUDICHUM suggested the calculi were in active process of formation, and, therefore, no time had been afforded for facetting or smoothing.

October 28th, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

Mr. SPENCER WATSON showed a foreign body removed from the eyeball. It was a piece of cast iron a quarter of an inch thick and one sixth wide. It had remained embedded in the vitreous humour for a month, where it had set up violent inflammation and sympathetic irritation of the uninjured eye in spite of active antiphlogistic treatment; after enucleation the pain and other symptoms began to abate, and the sight of the sound eye to improve.

Mr. DE MÉRIC asked whether after operation for removal of shots, &c., the eye left a stump of a character satisfactory for applying an artificial eye; also whether much scooping of the eye for removal of foreign bodies did not do more harm than the foreign body itself.

Mr. BRUDENELL CARTER thought Mr. de Méric's remark raised a point of some importance. He described the best method of removing an eye, and stated that complete removal was preferable to partial. He mentioned a case he had lately seen in the north of England where two shots had entered at the same aperture, and in which he advised removal; this course was justified by the result. He thought removal was called for, where the injury was more than very slight, and that if we erred at all in removal, it was on the side of safety.

Mr. SPENCER WATSON replied briefly, saying that he concurred

generally in Mr. Brudenell Carter's remarks, and mentioned a case where a cup of bone was found at the end of twenty years, and where a shot remained in the eye during that period.

Dr. EDWARDS CRISP brought forward three cases of

HÆMORRHAGIC SMALLPOX,

one of which he had at first thought was an example of cerebro-spinal meningitis. Models were shown. Hæmorrhage occurred into the skin and from the mucous membranes; he advocated re-vaccination when smallpox was epidemic.

Dr. BRUNTON had lately had eight cases of hæmorrhagic smallpox, only one of which recovered. He had noticed remarkable clearness of mind in these, and quite concurred with Dr. Crisp on this point. The case that recovered was treated with one minim of tinct. aconite every half hour.

Dr. THUDICHUM hoped he had not heard Dr. Crisp aright when he stated that it was the recommendation of Mr. Simon, "that re-vaccination was not needed under puberty," and that this advice had largely contributed to the great mortality in the late epidemic. This was contrary to facts.

Dr. ROUTH wished to know the treatment adopted. The omission of observations on the temperature was serious. He advocated the use of all remedies lessening temperature.

Dr. CRISP, in reply, said that the course of action recommended by the authorities was answerable for a great deal of the mortality in the late epidemic.

Dr. COCKLE then read a paper :

ON THE CONNECTION BETWEEN OCCLUSION OF THE LEFT CAROTID ARTERY, AND THE EXISTENCE OF LAMINATED CLOT IN THE SAC OF AORTIC ANEURYSM.

The author pointed out that the mere pathology of aortic aneurysm was, as it were, exhausted, and that the chief interest would henceforward centre in the treatment of the disease. Of late a marked impulse had been given in such a direction in Italy, Russia, and in this country. Ciniselli had achieved satisfactory results from galvanopuncture; but still there were certain drawbacks to its employment. He had ventured to bring forward a series of cases calculated to show that there existed a connection between occlusion of the left

carotid artery and formation of clot in the sac of the artery. In the first category were cases in which nature had thus filled the aneurysm, and in the second were cases in which the result had been artificially induced, either directly or indirectly. The case in which the artery was tied by Mr. Heath with the direct intent of checking the aortic aneurysm was published in the 'Clin. Soc. Trans.,' 1872. Remarks were then made as to the proximate causation of the formation of clot in the aneurysm and hinting at the difficulties of explanation; the author concluded by briefly alluding to the possible accidents attendant in such, contending that in nowise did they contra-indicate the operation.

Dr. CRISP said that twenty-eight years ago, in his Jacksonian Prize Essay, he suggested the principle of pressure or ligature advocated by Dr. Cockle, and also foretold in that essay that many of the lesions of the eye and ear would be found to be due to disease of the smaller vessels.

Dr. ANSTIE ventured to put in a word for galvano-puncture, which promised well even when the aneurysm was in the aorta, as De Cristoforis had shown as well as Ciniselli. In their cases the cessation of movement of the needles showed coagulation. He wished to remove from the minds of the Fellows the notion that the operation was either serious or dangerous. De Cristoforis has shown that it was not at all so. He did not dispute the value of Dr. Cockle's remarks, but thought galvano-puncture should be resorted to first.

Mr. BRUDENELL CARTER mentioned a case which occurred in St. George's Hospital, when, after failure of ligature, galvano-puncture was resorted to, but the patient died shortly after. He also quoted a second case where galvano-puncture failed.

The PRESIDENT asked Dr. Cockle why he selected the left carotid for ligature in cases of aneurysm of aorta?

Mr. CHRISTOPHER HEATH, as the original operator, wished to say that the recession of the sac was marked in distal ligature; the difficulty of diagnosis between aneurysm of the aorta and of the innominate was very great, and the left carotid was selected because it was branch next beyond the aneurysm. The operation in a recent case succeeded without the formation of a drop of pus; he used the catgut ligature, but did not attribute the success and non-formation of pus to the use of carbolic acid which had been absurdly lauded.

Dr. COCKLE, in reply, hoped Dr. Crisp would not think he

depreciated his work, which he regarded as classical. He was also indebted to Dr. Anstie for his remarks. The reason why the left carotid was selected was because it was shown to be the most expedient.

November 4th, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

Mr. DAVY brought forward some new retentive drainage wires, and explained that after a fine puncture a piece of wire, having Holt's india-rubber wings attached, was introduced and answered admirably.

The PRESIDENT asked if the wire caused much irritation.

Mr. DAVY said the size of the body introduced was material.

The PRESIDENT thought it was an important matter; he had used a roll of gutta-percha tissue with much success.

Dr. ROUTH asked whether Mr. Davy had used his plan in cases of sinuses of the female genitals where the pus was often so offensive.

Mr. DAVY had used it in anal abscesses, but without any lessening of the fœtor.

Dr. MACKNIGHT, of the U.S.A., exhibited

A NEW ARTIFICIAL LIMB.

The material was raw ox-hide and was very light; the specimen exhibited had been worn for six months. No shoulder-strap was required; a linen cap was placed on the limb and drawn down into a bucket, which was a model of the stump, with a little allowance for the circulation of air; the limbs could be made for very young children, and were in use even by children three years old, the price for a full-sized limb would be about £20.

Dr. WILTSHIRE had under his care a lady, who had frequently aborted, as she asserted, from wearing an artificial leg. She had sought a lighter limb, and had a leg made by a Polish mechanician with ox-hide, weighing about three pounds, and which appeared to be of a like description with that shown by Dr. MacKnight.

Mr. ROYES BELL thought the subject of importance, as he had lately seen a case where the stump required to be removed because of the irritation of bone caused by wearing too heavy a limb.

Mr. DAVY was of opinion that a good artificial limb should be noiseless and washable.

Dr. MACKNIGHT said that one advantage of this leg was that perspiration rather hardened, than softened, the limb; that it was quite impermeable to water, and could be applied even when there was no stump.

Dr. GODSON showed a case of

HÆMATOMA OF THE VAGINA.

The patient, aged twenty-three, was admitted into St. Bartholomew's Hospital complaining of abdominal enlargement and uterine hæmorrhage. Ten days after her admission a vesicular mole was discharged, and she left the hospital. She was readmitted, and upon careful examination the vaginal entrance was found to be obstructed by a peculiar looking swelling, about the size of a walnut, situated on the anterior wall immediately below the urethra; this was opened and appeared to consist of firm blood clot, with a covering of mucous membrane very much congested. A further swelling was afterwards discovered occupying the greater part of the roof of the vagina. The removal of the sound was followed by the discharge of a quantity of very fetid purulent matter; there was no hæmorrhage; she gradually became worse and was removed into a medical ward. The whole of the anterior wall of the vagina became involved, and she died on the 31st October. At the autopsy the peritoneal and pleural cavities were full of pus; pyæmic nodules were found in the right lung; the liver and kidneys were greatly degenerated; the heart and stomach were natural. The uterus was four times its natural size, tissues pale and soft, lower surface covered with black detritus and deeply ulcerated, the whole surface containing a quantity of pus, there being no retro-uterine hæmatocele. Dr. Godson thought the case rare. Dr. McClintock says, "I am not aware of a case where a thrombus formed spontaneously at the vulva in the non-gravid state, the spontaneous occurrence even during pregnancy is of extreme infrequency." He relates a case, occurring in the seventh month of pregnancy, in which suddenly there appeared a tumour the size of a large walnut, of a deep purple colour, protruding from between the

labia; it was sensitive to the touch, tolerably firm, and took its origin from the anterior wall of the vagina, a very short distance from the meatus urinarius. The situation and the size exactly corresponded with the present case.

Dr. THEODORE WILLIAMS said, one interesting point was the connection between the pyæmia and the miliary tubercle. Were the tubercles secondary to the pyæmia? If so, the case resembled the experiments of Dr. Sanderson on tuberculisation in guinea-pigs.

Dr. GODSON said the patient had had several attacks of hæmoptysis in previous years.

Dr. WILTSHIRE thought the case afforded a good text wherefrom a sermon might be preached on the damages following abortions and such like. He concurred in Dr. Williams's remarks; similar thoughts had passed through his own mind. The case appeared to be one of plugging of the pelvic veins and secondary thrombosis, after which probably pyæmic symptoms set in.

Dr. BERKART thought it would be difficult to prove that plugging of veins caused pyæmia. The fact that hæmoptysis occurred first, looked as if the formation of tubercle was of old date.

Dr. ROUTH said that the question opened several points for discussion. If thrombosis was common after delivery at full term, why should it not be so in the earlier months? He thought pyæmia was secondary to thrombosis; he was of opinion that the treatment had not been sufficiently energetic, and doubted the value of Condyl's fluid; iodine was much better.

Dr. GODSON, in reply, said the brain was healthy, and that pyæmic symptoms set in long after the existence of thrombus. The thrombi were in and around the veins.

Mr. JABEZ HOGG read a paper on

THE RELATION OF CATARACT, STRICTURE OF THE URETHRA, AND ENLARGED PROSTATE.

Stricture of the urethra had not yet been noticed as a predisposing cause of cataract. It might arise from a change in the specific gravity of fluids and the retention of urinary salts in disease of the bladder, &c., which was sufficient to cause opacity of the dioptric media and disorganisation of the vitreous. The author's daily experience, confirmed by work in the post-mortem room, showed something more than an accidental connection between lenticular opacities and stricture. Mr. Hogg having satisfied himself of this fact, and being

particularly anxious to ascertain whether the same circumstance had attracted attention in an institution where many sea-faring men were constantly under treatment for stricture and other diseases of the urinary organs, gathered certain facts which seemed to point out a correlation of cataract, stricture of the urethra, and enlarged prostate. The general results of fifty-six post-mortem examinations were then given, in seventeen of which opacities were detected, three were suspicious, as in each case the patient complained of defective sight, and five cases were also set down to ambliopia or amaurosis. With regard to the relative frequency of stricture and prostatic enlargements, fifty-three suffered from the former and thirty-five from the latter disease. The two diseases frequently, but not always, occurred together, but in these cases only did the existence of stricture admit of doubt. The bladder was diseased in nineteen of the patients, and in two, fatty degeneration of the muscular walls was observed. Mr. Hogg said that well-marked indications of premature old age were noted and might have exerted some influence in predisposing cataract; but that too much weight should not be placed upon such a circumstance, and in his judgment it did not invalidate his conclusions, and, therefore, quite apart from this, he was satisfied that stricture of the urethra, as well as certain morbid states of the prostate gland and bladder, is a frequent predisposing cause of change in the dioptric media of the eye.

The PRESIDENT thanked Mr. Hogg for his paper, and said it was suggestive; the connection between kidney disease and eye disease was important and well known. Obstructions in the urinary passages gave rise to disease of the kidneys, and he would ask were those organs diseased in Mr. Hogg's cases? Was cataract more common in females than in males? If so, how were such cases accounted for? Diabetes had not been mentioned, but there were two cases of carbuncle, which was often coincident with diabetes.

Mr. ROYES BELL thought disease of the prostate was a senile change; he would like to know the number of cases in which albuminuria was present.

Mr. DAVY had not noticed the coincidence of opacity with urethral disease; he concurred in the President's remarks. The lens was delicate, and soon showed changes in the organisation.

Mr. HOGG thanked the President for his kind remarks. In

several cases he regretted to say that the kidneys were not examined by himself, but in fifty disease was detected. The presence of sugar had not the same weight now as used to be thought, as it was shown to be a normal constituent in certain tissues; albuminuria might also exist without eye affections. Cataract was more common in females, but was then due to kidney disease.

November 11th, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

Dr. RICHARDSON read a paper on

THE TREATMENT *IN EXTREMIS* OF ACUTE CASES
OF FIBRINOUS DEPOSITION IN THE HEART.

He said that when twenty-two years ago he revived the subject of the nature, diagnosis, and treatment of fibrinous deposition in the heart during life, he then met two classes of objectors in the course of the debate. One esteemed Fellow, taxing his labours as visionary, had asked the severe question, Whether the paper had been before the Committee of Reference? Another equally esteemed Fellow said, that if the facts were as had been stated they served but to raise up a hopeless knowledge for medical men, therefore, *cui bono*? By repeated experimental proof he had made it a demonstration that fibrin does in some cases separate in the heart during life, while from clinical observation he had been enabled to point out the symptoms indicating the fact of such separation. The second objection had been met with much more difficulty, and he had not, although so many years had elapsed, ventured to speak of it in the hope of removing it. Year after year he had been called to see and find cases *in extremis* where death was clearly the result of fibrinous separation, and he had discovered no opportunity of affording distinct service. At last he saw this state of doubt passing away, and he might venture to speak of some method of approach toward success. The author then referred to the excessive mortality of the cases he had seen. They included cases of croup in children,

of pneumonia, of peritonitis, of ovarian operation, of parturient cases before and after labour and with and without phlegmasia, of erysipelas, of scarlet fever, and of some obscure cases in which nothing was proclaimed until the appearance of the fatal symptoms, except what was called cold or febricular or remittent feverishness. After describing the cases in detail, he continued by stating that, in his experience, recovery after fibrinous depositions had become actually developed did not occur in more than 3 per cent. Of all classes of disease, croup, he believed, yielded the largest number of examples; after that, diphtheria; and after that, the puerperal condition and peritonitis. He proceeded to place before the Society in a revised form the special points of diagnosis of fibrinous separation as occurring (*a*) on the right side, (*b*) on the left side of the heart; then he noticed anew the condition favouring the depositions; under this head, especially, he named increased local heat of parts involving large veins as of the extremest importance. For example, erysipelas, involving the skin over the lower extremities, was exceedingly dangerous. He was opinion that the local increment of heat was in such cases sometimes the only just cause of danger. The increased temperature of blood in the veins produced the pectous condition in minute portions of fibrin, and semi-solid little masses of fibrin were formed and carried into the heart to become nuclei or centres for the larger separations. Sudden general or systemic increment of heat, as in certain cases of apoplexy, lead to separation in the larger vessels and in the heart itself. The greater portion of the paper was devoted to the subject of treatment in cases of fibrinous deposit, and especially in cases *in extremis*. The author here first dwelt on what was bad treatment. He said, so soon as the symptoms of deposition had become developed all influences that had a depressing effect upon the heart ought to be instantly withdrawn; mental influences telling upon the emotions should be avoided. Sometimes the great distress exhibited by the sufferers, the distress of the dyspnœa, particularly, tempted the practitioner to give opium. This practice was fatal, and could only be defended on the doubtful ground that all treatment was useless except to secure euthanasia. In cases of croup it was often a question whether tracheotomy ought to be performed to relieve dyspnœa, it being uncertain whence the dyspnœa proceeded, whether from obstructed respiration or obstructed circulation. In such instances the diagnosis was simple, and when it was clear that

the dyspnœa was cardiac, the operation being useless, was better avoided. But in mixed cases, or in cases of doubt, Dr. Richardson was inclined to think the patient should have the benefit of the operation. In purely defined instances of fibrinous separation, the practitioner having determined what shall *not* be done, has to settle what shall be done. The first element of treatment, especially when the separation is on the right side, is to give absolute rest of the body in the recumbent position, for the heart working under embarrassment can bear no undue fatigue, and at the same time every active motion increases the danger of loosening the fibrinous mass and of allowing it to float into the pulmonary artery. Rest secured, there should be given as much food as the stomach will bear without distension from flatus, milk rendered slightly alkaline by limewater and charged with a little of Liebig's extract of meat being on the whole the best food. The body, if it be cooling, should be kept warm by external dry applications. Sandbags are the best when they can be easily procured, and the temperature of the air should be sustained at 60° F. or even 70°, the air being also kept dry. As to internal remedies the author had at first inclined to the free exhibition of alkaline solutions, especially of ammonia, but in a case where he carried out this treatment several years ago, using the bicarbonate of ammonia, and which terminated fatally after several days, although the concretion was found to have greatly softened and broken up, the blood was reduced to such an extreme degree of solubility, and the corpuscles were so extensively destroyed, that he had found the remedy as serious as the malady. He had suggested the injection of ammonia by the veins in these cases, but had held back, for the reason stated above, from following out the idea. He had tried inhalation of ammonia, but without sufficient success to warrant enforcing the plan. Lately, seeing the all but invariable fatality that followed the fact of depression, he returned again to the use of ammonia as a remedy by administering it in large and repeated doses in combination with iodide of potassium, using not as before a salt of ammonia, but the liq. ammon. of the Pharmacopœia. To an adult he administered ten minim doses of the liq. ammon. in iced water every hour, with three- to five-grain doses of potassium iodide every alternate hour. This treatment has been followed by a degree of success he had never anticipated. Nothing could be more remarkable than the fact of the quantity of ammonia that could be administered without danger, except the fact of the degree

of fluidity of blood and of blood-corpuscles that could be recovered from. In proof of this he detailed two cases in which the treatment had been followed out with the effect of entirely relieving the heart when death seemed all but certain. One of these cases had ended in slow but entire recovery, and the other had progressed favorably for nine weeks. The addition of alcohol to the treatment of these cases was then discussed. The direct action of alcohol in these cases was unfavorable when taken alone, but whenever the heart's action was beginning to fail, mixed with ammonia, it might be given with advantage; the solution of ammonia in alcohol might then be substituted for the aqueous solution, or brandy might be given in half-ounce doses every hour. Alcohol, however, was only to be held in reserve as an adjunct rather than a remedy. The course of the symptoms during recovery, the dangers that appeared, the changes of the blood, and the risk of secondary pathological modifications in remote organs, and especially in the spleen, were described and subjected to practical comment. In conclusion, the author stated that prognostics were much more favorable when fibrin had separated on the left than on the right side of the heart, the breaking away of the fibrinous mass on the left side being followed sometimes by immediate relief to the heart and by ultimate recovery. He mentioned a case where he had been summoned from home to attend a patient whom he left apparently in *articulo mortis*, and he was only able to comfort the friends with the hope that the concretion might possibly break away and the heart become relieved. Shortly after he had gone, the event thus looked for actually occurred; the semi-conscious patient was almost immediately relieved, and except for some temporary numbness of the lower extremities, the concretion being carried into the abdominal aorta, recovery was completed without an unfavorable symptom. Although a much larger experience was demanded to improve the work he had set forth, Dr. Richardson felt, nevertheless, that a distinct advance had been foreshadowed for a class of cases that had been considered hopeless. He thus felt it his simple duty to lay this communicative instalment as it was, and nothing more, before his fellow-practitioners of the healing art.

The PRESIDENT proposed a vote of thanks to Dr. Richardson for his able and suggestive paper, which was unanimously accorded. The President felt that the ammonia treatment held out great hopes of relief. He would ask, did opium tend to clotting? he

thought it did, especially in ovarian and other abdominal operations.

Dr. SANSOM mentioned a case of what he at first took to be hysteria; afterwards phlebitis in popliteal vein declared itself, which was followed by symptoms of plugging in the right side of the heart and impending death. Ammonia was given freely, with marked benefit. Phlebitis of the other leg came on with typhoid symptoms, when sulphate of soda was given, and ultimately the patient recovered.

Dr. FAYRER said, he had been fortunate in gaining the information he wished to glean, and that from the most competent authority. Clotting in the right side of the heart was a frequent cause of death, after operation, in India. He regarded it as a result not only of excessive heat, but of change in the blood, which he thought was blood-poisoning; the change, he believed, an ante-mortem one; it might follow even slight operations.

Dr. HABERSHON agreed that we owed much to Dr. Richardson not only for this, but also for all his previous valuable work. He would ask him, did he recognise classes of the affections originating with diseases of the lungs or heart accompanied by retention of blood on the right side of the heart? Such cases should be distinguished from those originating in loosened clot from phlebitic veins. He mentioned a case in which there was pneumonia accompanied by gonorrhœa and inflammation, and plugging of the prostatic veins. He bore testimony to the value of ammonia and quoted cases in point.

Dr. ROUTH stated that in uterine surgery fibrinous deposit was a common cause of death. He asked, why should not ammonia be injected directly into the blood?

Mr. W. ADAMS mentioned cases in support of Dr. Richardson's statements. They were cases of erysipelas of the legs, where the period of danger was on the subsidence of inflammation.

Dr. ROGERS asked, to what extent ammonia might be pushed after abdominal operations?

Mr. BOND asked, how far these cases might be treated by the Turkish bath?

Dr. R. J. LEE mentioned a case which occurred in the Westminster Hospital after erysipelas, in which a portion of clot was washed off the external iliac vein and caused death.

Dr. RICHARDSON, in reply, said that the effect of opium, if

given when the clot was about to form, was most fatal in the lower animals. It killed carnivora when given in poisonous doses by causing clotting. The terms embolism and thrombosis were barbarous, and had clouded and thrown back knowledge for some time. He was glad to hear Dr. Fayrer's experience. Heat and a suppression of function had a great deal to do with clotting, perchance, too, in malarial regions something might be carried into the blood which caused clotting, but he did not know what was meant by blood-poisoning. To Dr. Habershon he would say that before his (Dr. Richardson's) papers something had been done, but only in a fragmentary way. He gave some historical details, and especially praised the work of Goold. He thought he had made a classification of the kind suggested by Dr. Habershon, and mentioned a case of sudden death after gonorrhœa in a boy. He preferred the liquor to the carbonate of ammonia, because it was a more flexible agent; it would escape from the body through every channel, while the carbonate would only escape through the kidneys. As regards injecting ammonia there was some danger in the process, which required frequent repetition; if he used it in that way at all he would do so by means of a thread passed through a vein, one end of which was dipped in a solution of ammonia like the end of a wick; as much as three ounces of liq. ammon. might be given in the course of a day. The dissolution of blood-corpuscles would be the best guide as to the extent it might be carried. Turkish baths would be useful, if practicable. As regarded stimulants, it was a bad practice to give them indiscriminately; they should be stopped when the heart answered to the stimulation.

November 18th, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

Mr. BOND related an interesting case of

POISONING BY SULPHURIC ACID.

A woman, aged thirty-one, was found in St. James's Park, on her hands and knees, vomiting violently; she was brought to King Street Police Station in a very exhausted state, but sufficiently conscious to make it known that she had taken sulphuric acid; she appeared to be in great agony. Copious draughts of chalk and water were administered, and she vomited a large quantity of black matter, apparently food recently taken. She was removed to an infirmary, and during the night was delivered of a full-grown child. She rallied and gained strength, progressing favorably for about a fortnight, when she complained of sickness and of difficulty in swallowing food. On examination a large circumscribed swelling was found commencing opposite the cricoid cartilage and extending down the course of the trachea two inches, and moving on deglutition. Mr. Bond attempted to pass the tube of a stomach-pump, and also a No. 6 gum-elastic tube, but without success. In a few days she was quite unable to take any food or fluid whatever. He was advised against the operation of gastrotomy, and instead, he inserted a piece of stiff copper wire into a No. 6 tube, and after much difficulty forced it through the stricture into the stomach, and injected sustenance twice a day, the size of the tube being gradually increased till the stomach pump could be passed easily. The swelling disappeared; but the woman gradually grew weaker and died. At the post-mortem examination the mouth and the fauces were found to have quite recovered from the effects of the acid, and on opening the œsophagus no trace of stricture nor of any exudation was detected, but there was complete disappearance of the mucous membrane. The

mucous membrane of the stomach was quite black and partially detached at the cardiac extremity, and underneath it patches of fibrinous exudation, a quarter of an inch thick, were found. The deductions Mr. Bond drew were—1st, that a stricture of the œsophagus may be dilated without risk, and that probably the fibrinous exudation observed under the coats of the stomach had also taken place in the œsophagus and was the cause of the stricture; 2nd, that the operation of gastrotomy would have been ineffectual, as the woman died from the injury done to the coats of the stomach.

The PRESIDENT asked what evidence there was of stricture? Was there not merely spasm and no real organic stricture?

Mr. BOND thought there was a stricture, as there was an external swelling over the œsophagus and the catheter was arrested in its passage.

Mr. ROYES BELL showed a foot which had been amputated by Mr. Hoar, of Maidstone. There was a tumour in the sole of the kind which used to be called fungus hæmatodes.

The PRESIDENT said that the soft cancers were much more common in the head than in the foot, and looked on the specimen as rare.

Mr. HOGG thought the fungous foot of India was in some way allied to this.

The PRESIDENT thought the fungous foot of India was rather a general infiltration of the whole tissues of the foot accompanied by some parasitic growth.

Mr. W. ADAMS thought the disease was rare; he had met with two cases, and in one complete recovery took place.

The PRESIDENT showed a specimen of

EXTENSIVE HIP-JOINT DISEASE.

The patient was a man suffering from advanced phthisis, which precluded operation; the disease was clearly the result of a local necrosis; a small sequestrum of bone projected into the acetabulum, and had set up inflammation and absorption of the living bone. These sequestra were in olden times called "tubercle."

Dr. ROUTH read a paper on

OVERWORK AND PREMATURE MENTAL DECAY AND THEIR TREATMENT.

After some well-merited praise to the efforts of Dr. Richardson in the same direction, and some remarks on the nature of the present hardworking and competitive age as compared with former ages, he proceeded to show, upon the authority of Dr. Elam, that there had been a very large increase of the mortality from diseases of the brain in England, the increase of the population being 30 per cent., while the mortality from diseases of the brain had increased tenfold. Whilst deaths from paralysis and apoplexy had increased from 10,000 to 22,000 annually, those from insanity had also nearly doubled; and he showed that there was a direct relation in this increase with the agitation of the times. Dr. Maudsley and others had endeavoured to show that the numerical increase was due to the increase of population, to better search after, and more complete segregation of, the insane. In the last published reports of the Commissioners of Lunacy the ratio per 1000 of the total number of lunatics and persons of unsound mind showed an increase, each year, from 1869, when it was 1·86, down to 1872, when it reached 2·54. The author then enumerated the symptoms of mental decay, showing that they resembled the gradual changes that came over old people, and yet were similar to those induced by venereal excesses in both sexes, except that in the latter case there were symptoms of spermatorrhœa which were absent in cases suffering from overwork. In both cases the tendency was towards the production of idiocy from softening of the brain and insanity. He said that there was reason to believe that the immediate cause of these symptoms was deficiency of phosphorus in the brain, the author endeavouring to prove this by considering *seriatim* the following points:—1st. It is proved chemically that a man grows older and mentally weaker, or becomes idiotic, as the brain contains less phosphorus; this was shown by the analyses of Heritier. 2ndly. The solidity of the brain in a measure depended on “protagon,” a phosphoric compound, and those foods which were richest in phosphorus were found by experience to renovate weakened brain-power most speedily, such as shellfish and fish generally. 3rdly. The assertion made by some that phosphorus could only be assimilated by previous conversion into phosphoric acid was combated, the effects of the two being shown to be per-

fectly different, phosphoric acid producing in large doses fatty degeneration of the heart, liver, and kidney, whereas phosphorus produced necrosis of the jawbone and excited the nervous and sexual system. The opinion of Dr. Von Bibra was also quoted in evidence of this: phosphorus also induced or removed congestion of the brain. 4thly. Dr. Routh showed that those diseases produced by softening nervous matter, were precisely those which were cured oftentimes by the internal administration of phosphorus, viz. certain forms of paralysis, eczema, and other skin affections, cerebral congestions, with great debility and insomnia. The authority of several writers was cited on these points—Delpech, Prof. Fisher of Berlin, Dr. Eames, in the 'Dublin Journal,' Dr. Burgess, and Dr. Hammond, of New York. 5thly. The internal administration of phosphorus, whether in its allotropic form or as the "solutio phosphori medicati"* prepared according to Dr. Hammond's formula, was recommended. Some cases bearing out the author's views were subjoined, but not read, owing to the lateness of the evening.

Dr. FARQUHARSON thought that this high-pressure age involved competition almost before the child was out of petticoats; he could not get into a public school without a severe examination. Many great minds gave way under too much pressure and worry. This was the case very much in England. The incomparable workers, the Germans, were wiser; their hours were earlier. He had seen overwork in boys set in as a sharp febrile disorder. There were symptoms of severe brain disorder which was followed by loss of mental power. Care was required in allowing patients to resume their ordinary active intellectual work. It was very important to procure sleep: small doses of narcotics were not so useful as fuller doses.

Mr. HOGG asked whether any ophthalmic examination had been made.

The PRESIDENT thought it was rather overworry than overwork that was injurious to the full-grown brain. Neglect of ordinary hygienic rules, accompanied by worry and much work, was injurious. Overwork, he thought, was more injurious to the young than to the adult.

Dr. ROUTH thought worry was evidence of failing power. Anything which exhausted phosphorus in the brain caused failing mental power; its restoration was, therefore, indicated.

* To be had of Mr. King, Crawford Street, W.

November 25th, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

Dr. LICHTENBERG showed two men who had been subjected to

RHINO-PLASTIC OPERATIONS.

This operation had been introduced into this country by a young surgeon, but had not found much favour with our principal operators, past as well as present; but although the restoration of a nose, or of a part of a nose, was a poor substitute for the original, yet the operation was well worth undertaking in preference to the patient wearing an artificial nose. The first case was operated on for the restoration of a whole nose. The flap was taken from the right side of the forehead exactly one third larger than the model (previously prepared in wax), allowing one inch for the length and three quarters of an inch for the columna, the bridge being almost an inch wide; it was then adjusted by about twenty-five fine silk sutures upon the parts previously pared and well dissected from the underlying tissue, the columna being fastened to the upper lip, in which a deep horizontal incision had been made to receive it. The operation lasted two hours and was followed by scarcely any constitutional disturbance. The last sutures were removed on the fifth day, perfect union having taken place. The author called attention to the importance of leaving a sufficient portion of skin attached to each ala for turning in to form a complete nostril. The second case was operated on for the restoration of the right ala which the patient had lost through lupus, this disease having left the neighbouring parts in a very unhealthy state. The operation was followed by a severe venous stasis in the flap, which gave way to repeated application of leeches. The portion of skin which had been turned in at the nostril became partially gangrenous and had to be removed without further injury to the nostril; the colour of the nose was much improved from the transplantation of the healthy skin from the forehead.

The PRESIDENT congratulated Dr. Lichtenberg on his excellent

cases ; his own experience was but limited and had not been very encouraging. He had gleaned from Dr. Lichtenberg's paper that his error had been in sparing sound skin : he had not taken enough. The only case he had seen equal to Dr. Lichtenberg's was one where the late Mr. Skey had operated, and he had made such a good Roman nose that he (the President) could hardly believe it was the result of rhino-plasty until he had verified it by inquiry ; he had not thought of taking so much as an inch for a septum. He thought that in the second case the skin might have been taken from the cheek ; the turning of the edge for an ala was an excellent addition to the operation. He would ask whether Dr. Lichtenberg had any rule as to dividing the twisted portion of the skin at the root of the nose.

Dr. LICHTENBERG, in reply, thought too much skin could hardly be taken ; the nose took about a year to shrink. The diseased skin in the second case was very considerable in extent, and his object was to go away from it as far as possible ; he was confirmed in his opinion by Diffenbach : no skin was so well adapted for making a new nose as that of the forehead ; it healed, and if there was healing by the second intention, there was shrinking. The twisted portion should not be divided too early, certainly not under three or four months.

Dr. BROADBENT then read

A STUDY OF A CASE OF HEART DISEASE, PROBABLY MALFORMATION.

The patient, a young Scotchwoman, aged thirty-one, who had never had acute rheumatism or an illness of any kind, came under observation on the 7th April last, having been ailing for six weeks, but doing her work up to the day before admission into hospital. She was well nourished, had a good colour and facial expression ; her respiration was tranquil, but she felt ill on standing, and the pulse at the wrist was 120—130, irregular in force and frequency, excessively small and feeble, and sometimes imperceptible. On examining the heart the apex beat was a little displaced outwards, and the area of dulness slightly larger than normal, extending for an inch, or an inch and a half, to the right of the lower sternum. The impulse was short, sharp, and like a tap ; the first sound loud and sharp, resembling an exaggerated second sound at, and near, the apex. In the third left intercostal space close to the sternum

was heard a short, smooth, diastolic murmur, but only over a very limited spot, which could be covered by the stethoscope. It was at first not easy to decide whether the heart affection was old or recent, but the subsequent progress left no doubt that it was old. Later, the apex beat disappeared from the situation at which it was first felt, and the area of dulness diminished, while a vibratory impulse was perceptible in the third space, extending outwards an inch and a half from the edge of the sternum, and more feebly below the upper portion of the sternum. The second sound was strikingly reduplicated at the base; the diastolic murmur already mentioned was heard at the left edge of the sternum. So far as the sound went the case resembled very much constriction of the mitral orifice, but the diastolic murmur was difficult to explain, as it was heard over too small a spot to be due to aortic regurgitation, a supposition which was moreover contradicted by the reduplication of the second sound. The patient took first iron and quinine, to which in a few days was added infusion of digitalis; there was marked improvement in the general condition and in the physical signs until April 19th. Ten days after admission she had congestion of the lungs and elevated temperature with distress in breathing. The heart became greatly distended during the attack, and not only dulness, but impulse, was found to the right of the lower sternum, showing that the dilatation was chiefly of the right ventricle. The sounds became audible over the entire chest, front and back. A systolic aortic murmur was also developed by the powerful action of the heart, and was not subsequently lost. The presystolic rumble at the inner side of the apex became for a short time a murmur, and the vibration, an indistinct thrill. The diastolic murmur was at one time inaudible, but it again appeared, varying in length and intensity, with the evidence of aortic obstruction afforded by a systolic aortic murmur. The extremely feeble pulse became more compressible, and if the murmurs alone had been taken into account they might have been explained by mitral narrowing and aortic obstruction and incompetence. The state of the walls and cavities was not, however, such as would have been indicated by these valvular affections, and, as has been previously stated, there were grave objections to the suppositions of regurgitation from the aorta. The pulmonary congestion was of short duration, and the patient gradually improved, the physical signs varying somewhat. When she began to walk about an altogether new murmur

appeared, systolic in time, and audible about the fourth left interspace near the edge of the sternum, and over the lower end of this bone, *i. e.* below the spot where the diastolic murmur was heard so long. Taken alone this might have been attributed to tricuspid regurgitation. It seemed, however, to Dr. Broadbent that no combination of valvular affections would satisfactorily account for the whole of the facts of this case, *viz.* the absence of cause for symptoms of heart disease, the state of the heart walls and cavities, and the various murmurs and modified sounds, while a congenital malformation, which has been occasionally found without cyanosis, and has permitted of survival to adult age, might explain more or less perfectly all the phenomena. This malformation consists of narrowing of the aorta, together with a perforate or incomplete interventricular septum, leaving a communication between the two ventricles, the aperture being always near the base of the heart. On this hypothesis the explanation would be as follows:—In the early part of the ventricular diastole, when the ventricles in rebounding from the systole suck in the blood from the auricles, the left having thicker walls, and being the more powerful, might be expected to draw in blood from the right through the aperture in the septum, as well as from the left auricle, which would give rise to a diastolic murmur heard over a limited spot in the left third space; this would be variable in length and intensity, from the varying negative pressure on the heart by respiration. While the patient lay quiet, and no pulmonary complication existed, this was the only murmur heard; but when the heart's action became more excited and powerful, in consequence of pulmonary congestion, a systolic murmur was developed in the narrowed aortic orifice; and later, when she began to assume the erect position, which would increase the resistance in the systemic circulation without affecting the pulmonary circulation, the increased energy of the left ventricle forced a part of the contents through the orifice in the septum, producing the systolic murmur heard to the left of the lower end of the sternum. All the murmurs would then be accounted for, together with their variations; the reduplication of the second sound, which was so striking a feature in the case, must be assigned to want of synchronism in the closure of pulmonary and aortic valves, and this would be explained by the delay experienced by the left ventricle in expelling its contents through the narrowed aorta; the presystolic vibration sometimes felt by the hand, and

the presystolic rumble sometimes audible to the inner side of the apex, were probably incident to the dilatation of the right ventricle. The patient having so far recovered as to be able to return to her work, no opportunity was yet afforded of verifying or correcting the diagnosis, but it is not without profit to study complex and difficult cases without reference to that opportunity.

Dr. SYMES THOMPSON and Dr. ROUTH made remarks in the discussion that followed.

Dr. BROADBENT replied, and the meeting adjourned.

December 2nd, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

Dr. SANSOM exhibited a child, æt. 13 months, who had suffered from

LOCAL SUPPURATION IN THE RIGHT CHEST.

The child was under his care at the North Eastern Hospital for Children since April 29th, 1871. There had been signs of—1st. Pleurisy existing with symptoms of phthisis. 2nd. Absorption of pleuritic effusion, leaving density of the upper lobe of the right lung. 3rd. Softening of pulmonary structure with subsequent suppuration over the site of such softening, the abscess bursting externally. Directly afterwards the child progressed towards recovery until May 21, 1872, when a like suppuration took place over the lowest lobe. After evacuation of the pus the child rapidly gained strength, and was now in a fair condition. Dr. Sansom thought that in this case the commencement of suppuration was in the lung structure and not *ab initio* from empyema.

The PRESIDENT brought forward a man, æt. 24, suffering from a

TUMOUR OF THE ORBIT GROWING FOR FIVE YEARS.

He thought it was an ivory exostosis growing from air cells. The sight of the eye was good, although the eyeball was much displaced. He advised non-interference at first, as the vitality of such growths was low, but as the growth had become rapid he thought inter-

ference necessary ; for even the base of the growth was broad. He thought no harm could be done by operation.

Mr. HAINWORTH recollected a similar case twenty-five years ago, but it suggested a different view to that the President had taken. At the autopsy a fungoid growth was found at the base of the brain.

Dr. WILTSHIRE asked Mr. Hainworth if the case he mentioned presented any cerebral symptoms ?

Mr. HAINWORTH said they existed in the later stages of the case.

Mr. HOGG thought operation would be useful, and he looked for a hopeful result.

Mr. ROYES BELL also thought it a case for operation.

The PRESIDENT was not very sanguine, but thought interference was called for.

Dr. SYMES THOMPSON read a case of

PNEUMO-THORAX FOLLOWED BY EMPYEMA AND NECESSITATING OPERATION.

Sarah B—, æt. 23, was admitted into the Brompton Hospital for Consumption, Jan. 30th, 1872. Had been ill two years, suffering from bronchitis, inflammation of the lungs, and pleurisy (left side) three or four times. Had hæmoptysis also twelve months ago lasting three or four days, and two or three times since to a less extent. She was a delicate, clear-complexioned person with bright eyes and flushed cheeks, and on admission complained of difficulty in breathing, pain after food, palpitation with troublesome cough, and muco-purulent expectoration ; the tongue was furred, appetite variable. On examination the physical signs were, at left apex, respiration hard and feeble, crackling crepitus in front. Rhonchus and crepitation in spinous fossa behind ; breathing normal elsewhere. Pulse 108 ; afternoon temperature 100°.

February 23rd.—Crepitation extended throughout left side to base.

March 28th.—To-and-fro friction sound heard in the left spinous fossa.

April 6th.—Seized with severe pain in the left side, great dyspnœa and excited action of the heart ; the breath sounds were almost inaudible ; tympanitic percussion sounds were noticed on the front and back of the left chest, and it was evident that pneumo-

thorax had occurred. The pulse, which had been, since perforation occurred, too irregular and feeble to be counted, became steadier (136 a minute), and on April 11th the patient looked less distressed and the respiration was more tranquil.

April 13th.—The patient was raised in bed for the first time, to examine the bases of the lungs; the tympanitic percussion note was found to be replaced by an absolutely dull sound at the lower part of the chest. The daily morning temperature varied from 98° to 100° , and the evening temperature from 100° to 102° .

May 19th.—The dulness at the left base extended as high as the scapula; no respiratory murmur could be heard, but on the right side some crepitation was heard near the base of the lung.

June 13th.—Patient losing ground daily, paracentesis determined on, and three pints and a half of offensive purulent fluid drawn off; great relief followed, but on June 26th diarrhoea set in with much abdominal pain. Early in October a small opening was made to let out matter which had burrowed beneath the superficial tissues. The mouth became aphthous, exhaustion increased, and the patient died on the 10th October, 1872. At the post-mortem examination the right lung was found attached to the ribs by a few soft adhesions, unsoftened tubercle scattered thickly throughout the upper middle lobe and at the apex. The left lung was collapsed and occupied one third of the chest. There was a cup-shaped depression on the surface, the mouth of a communication through which a probe could be passed into the interior. The heart was pale and flabby. Liver internally fatty and much enlarged.

Remarks.—1. Perforation was preceded by signs of spreading disease, especially on the surface, calling for careful management, *e.g.* rest in bed, poultices or counter-irritants, cooling dietetics and medicinal treatment. 2. Were the distress and dyspnoea due to the presence of fluid? It was evident that the upper part of the pleural cavity contained air in free communication with the bronchi. The pressure, therefore, of the retained fluid could not exceed that of the atmosphere; but as the situation of the heart to the right of the sternum and the decided increase of dyspnoea, with increase of dulness, showed that the fluid exercised an injurious influence by its mechanical pressure, it was accordingly drawn off, and with unmistakable relief. 3. The question may be discussed whether it would not have been wise to keep both openings patulous. The anterior one was allowed to heal, the posterior one remaining free, being evidently in

the most dependent position possible. A drainage tube was introduced, but this opening was unintentionally allowed to heal and the fluid to accumulate. 4. But for the occurrence of diarrhœa, due to ulceration of bowel, recovery in this case might have occurred. Perfect compression of lung, implying no adhesions, and therefore but slight previous disease, was a favorable circumstance.

The discussion which followed referred to the cases brought forward by Dr. Sansom, and by Dr. Symes Thompson.

Dr. THOROWGOOD thought that when such symptoms occurred in the course of chest disease it was important to take special care of the patients; paracentesis appeared to be called for in this case and relief followed the operation. The complete collapse of lung after perforation, showed the non-existence of adhesions and was favorable. With reference to Dr. Sansom's case, mischief commenced in the lung, but whether the abscess was situated deep in the lung or on the surface, was difficult to determine. The case suggested whether it was justifiable to puncture and let out matter. If the admission of pus into the pleural cavity could be prevented such a course was advantageous.

Dr. HARE could not understand a cavity of the lung resulting in so much contraction as was seen in Dr. Sansom's case, and thought it rather empyema secondary to lung mischief. He mentioned a case in which a quantity of fœtid pus mixed with air was evacuated. The patient recovered. There was circumscribed empyema which was followed by shrinking of the chest walls. He thought that under the acute conditions mentioned a free use of leeches would be of great service.

Dr. THEODORE WILLIAMS agreed in Dr. Hare's view of Dr. Sansom's case, but suggested that the source of the pus might have been detected by examining the expectoration. Was it abundant, and did it contain yellow elastic tissue? In Dr. Symes Thompson's case he had quite agreed in resorting to operation. He should like to know the condition of the cavity at the post-mortem examination. He thought the prognosis of pneumo-thorax was very bad in hospital practice; in private practice it was much better. He had seen cases where the patients had completely recovered, and had been able to walk long distances, as much as thirty miles a day, without shortness of breath.

Dr. THOROWGOOD thought adhesion of lung to chest was the salvation of the patient and prevented perforation.

Dr. DOUGLAS POWELL considered that adhesion of the pleura depended on the nature of the disease.

The PRESIDENT thought the surgical question of the mode of dealing with pneumo-thorax was important: he had a strong feeling that making a free opening and inserting a drainage-tube was much the better plan; he condemned the simple tapping and the seton. German surgeons went so far as to suggest the removal of part of a rib; and though he did not advocate this, he thought it a step in the right direction.

Dr. SANSOM thought that any difference of opinion depended rather on terminology than anything else. The pleuritic effusion in his case had entirely disappeared, and then this was followed by circumscribed dulness. He thought the first lesion was in the lung, viz. caseous pneumonia which set up the empyema. The child was too young to enable him to collect any expectorated matters.

Dr. SYMES THOMPSON agreed with Dr. Hare in believing leeches were useful, but he thought the cases were exceptional. The shrunk cavity was about the size of a walnut; its walls were composed of dense tissue which sunk in water. Treatment might influence the character of inflammatory effusion. As regards the surgical aspect of the question, he thought bold measures were most successful; possibly the removal of a rib might promote approximation of chest walls and lung in bad cases.

Dr. DOUGLAS POWELL brought forward a case of

MEDIASTINAL TUMOUR,

occurring in a man, æt. 29, who was of healthy family, and had enjoyed good health up to November, 1870, when he had a severe attack of inflammation of the lungs, since which he had failed in strength and flesh, and in May, 1871, he attended the Brompton Hospital, under Dr. Powell's care. There was puffiness of the face, but no lividity nor any venous enlargement or alteration in the shape of the chest. The heart, however, was displaced to the right of the sternum, and its impulse was of a peculiar diffused heaving character, giving the impression that it was pressed forwards or to the right against the ribs. There was no mediastinal dulness in front, the left side anteriorly being hyper-resonant, except for an inch and a half at the extreme base. Posteriorly, however, there was dulness below the scapular spine limited in the axilla by a

slanting line corresponding to the division of the two lobes. The respiration was very feeble or absent over the dull region, and the vocal fremitus diminished or annulled. Dr. Powell pointed out how these two conditions of great displacement of the heart to the *right* of the sternum, with dulness and absence of respiration confined to the lower lobe of the left lung, could scarcely be accounted for on any other hypothesis than that of a morbid growth invading the left lung and heart from the posterior mediastinum. Subsequently, the patient found relief from a copious hæmoptysis. In August the dyspnœa became urgent, the dulness invaded the whole left front, except a small space at the top of the sternum, the heart's displacement was increased, and a rough systolic *bruit* became for the first time audible. Some venous engorgement and general œdema were now present. An exploratory trocar was inserted in the hope of removing some fluid, but without result, and the man died two days later. At the post-mortem examination the diagnosis was confirmed by the discovery of a large lymphomatous growth occupying the posterior mediastinum, invading the left lung, consolidating the whole lower lobe and the lower four fifths of the upper lobe, pressing aside the heart and involving the left auricle. Dr. Powell spoke of the difficulty there was of being sure of the absence of fluid in such cases, and regarded a puncture with a fine trocar as the only certain method of clearing up the diagnosis.

Dr. SYMES THOMPSON, as one of those who had diagnosed fluid in the pleura when no fluid existed, asked himself whether such an error could be avoided, and he felt that it could not, and he justified the exploratory puncture.

The PRESIDENT asked whether the pneumatic aspirator would not be better than a trocar?

Dr. POWELL had seen it used with success, but had not one at hand at the time.

Dr. THEODORE WILLIAMS asked whether many glands of the body were affected?

Dr. POWELL said that no other glands than those of the posterior mediastinum were involved.

December 9th, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

INFANTILE PARALYSIS TREATED BY THE CONTINUOUS CURRENT.

Dr. SANSOM treated the following cases by the current transmitted through the spine by the means of a large Pulvermacher's chain:—1. E. P—, æt. $2\frac{1}{4}$ years, admitted into the North Eastern Hospital for Children, June 26th, 1872; quite unable to walk, but irritability of muscles fairly good. Current for half an hour, night and morning; mist. ferri and ol. morrhuæ. Improved, and on the fourteenth day discharged, able to walk quite well. 2. M. A. M—, æt. 4 years, admitted 12th Sept. with inability to stand and rigidity of left arm with incurvation of the thumb. The child was rachitic, the condition had followed an attack of pertussis. *Treatment.*—Mist. ferri, current down spine for half an hour, night and morning, and after a fortnight current in addition for half an hour from nape of neck to palm of left hand. Great improvement followed. On Oct. 5th she walked very fairly, and very soon could run about the wards. Subsequently, at the Convalescent Home, she has been able to move her thumb at will. 3. E. C—, æt. $3\frac{1}{2}$ years, admitted Sept. 28th, unable to walk or stand, and no reflex action could be excited in the lower limbs. The condition followed an attack of measles. *Treatment.*—Mist. ferri, liq. strychniæ; current half an hour, night and morning. Greatly improved, and on Oct. 12th could stand and walk by herself; on the 23rd quite recovered. Though the collateral treatment may have had a share in the production of these good results, it appeared to all who observed these cases that the galvanism contributed largely to the restoration.

Mr. SPENCER WATSON hardly supposed that a current could pass from the spine through the anterior cords by merely applying

poles to the skin. He would like to know how the chain was applied.

Dr. ROUTH wanted to learn the influence iron and strychnia had exerted, and also the duration of the paralysis. If the patients got well in a year he thought the result good. He was satisfied with the chain, and considered also Stöhrer's battery very useful.

Dr. SEDGWICK reverted to Mr. Barwell's plan of injecting strychnia under the skin; he should like to know the opinions of the Fellows on this point. He should also like to hear more of the history of Dr. Sansom's cases, and thought we should seek higher up than the spine. The diseases often set in with cerebral symptoms.

The PRESIDENT thought the subject of Infantile Paralysis was one that called for more investigation. Where could he find reference to sclerosis of the anterior column of spinal cord? Paralysis attacked groups of muscles, and was generally paralysis of motion and not of sensation. Electricity could scarcely be regarded as a means of removing sclerosis of the cord; it was injurious in the earlier stages, and only used by himself in the later. He thought the interrupted current the best. Iron and cod-liver oil were good in the early stages, and in the later strychnia and electricity.

Dr. SANSOM, in reply to Mr. Watson, stated that there could be no doubt that the current traversed the spinal cord. The cases were chronic, and his treatment was applied in the later stages of the disease. He referred the President to the French edition of Niemeyer's work for a note of sclerosis of the cord by M. Cornil.

Dr. WILTSHIRE mentioned that M. Charcot had worked at the subject of *Sclérose en Plâques* in connection with the pathology of ataxy, and referred the President to his writings. For his own part, he thought the suddenness of attacks, and sometimes of recovery, indicated that occasionally, at least, cases were of reflex origin. Some patients got well of themselves, and he doubted whether sclerosis of the anterior column was a constant pathological change in such cases. Improvement of the general health was the chief thing to aim at. Electricity was valuable for keeping the muscles in action, so as to prevent fatty degeneration from disease.

Mr. STREETER showed an engraving illustrating the

TALIACOTIAN OPERATION,

which was not uncommon in India, and had long been performed,

originating during the Mahratta War, when it was the practice of Tippoo to mutilate his prisoners by cutting off the nose and the right hand, after which means were taken for restoration of the former.

The PRESIDENT brought forward a specimen of

FRACTURE OF THE NECK OF THE THIGH-BONE,

from a woman, eighty years of age, who died of erysipelas. There was a vertical fissure of the neck of the femur, which was much rarer than impaction. It was an extra capsular fracture of the neck of the bone produced by a blow from behind on the trochanter. The specimen illustrated the formation of a false joint.

The PRESIDENT also showed a very interesting specimen of

DISEASE OF THE SHOULDER-JOINT,

taken from a man, æt. 50, who had been treated for rheumatic pains without good effect. The abscess was opened, and half a pint of semi-purulent fluid discharged. He died suddenly after four days' illness. It was a case of acute disease of the joint producing slight symptoms.

December 16th, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

Dr. FARQUHARSON communicated a case of

TRAUMATIC PERICARDITIS.

The patient was accidentally stabbed while playing with a companion, the knife entering the chest close to the upper border of the sixth rib, and penetrating half an inch in depth. On recovering from the shock of the accident, symptoms of pericarditis supervened with a transient friction bruit, and signs of moderate effusion. A few days later it was evident that a considerable quantity of fluid had accumulated in the left pleural cavity, but recovery was rapid and uninterrupted, and the patient was enabled to return home twenty-one days after he first came under notice.

In considering the practical bearings of this case, Dr. Farquharson first referred to the very rapid disappearance of the friction bruit, and stated why he considered this due to moderate effusions in the sac, rather than to agglutination of the surfaces of the membrane. The quality of the fluid in the left pleura was next discussed, reasons were assigned for the belief that it consisted of blood, and in making a few concluding remarks on treatment, the author stated he believed rest, quiet, and avoidance of all disturbing causes, to be the true indication.

Mr. BRYANT referred to Dr. Fisher's able paper on the subject of wounds of the heart. There was no exact analogy between traumatic and other cases of pericarditis; he would use ice and such like, but neither antimony nor calomel.

Dr. SYMES THOMPSON asked whether in these cases blood escaped into the pericardium and separated into clot and serum, the latter being absorbed. He referred to a remarkable paper by the late Dr. Stroud, who speculated on the physical causes of the death of Christ. He agreed generally with Dr. Farquharson.

Dr. ROUTH would have given the patient small doses of turpentine as an astringent and as a stimulant. If blood did escape quickly and in quantity, the separation referred to by Dr. Symes Thompson occurred; but if only in drops, it did not do so. He could scarcely suppose much blood escaped into the pericardium in Dr. Farquharson's case. The treatment for pericarditis should be much the same, whatever its origin. He would use ice locally.

Mr. WILLIAM ADAMS mentioned a case which had come under his notice. A man had fallen on a small chisel, which punctured the heart. After a long collapse the man recovered.

Dr. WILTSHIRE asked what became of the solid portion of the clot referred to by Dr. S. Thompson.

Dr. SYMES THOMPSON said that he thought life was usually but short after the escape of much blood, and knew of no evidence of what became of the clot.

Dr. FARQUHARSON thanked the Fellows for their suggestions, and had he known the value of turpentine in shock, he would have used it.

Mr. BRUDENELL CARTER showed a man who illustrated the advantage of a new operation for cataract, which was devised by Dr. Taylor, of Nottingham. This operation would, he thought,

supersede most other operations for cataract, scarcely any irritation of the eye being produced. He related details of cases upon which he had performed this operation, and showed some drawings.

Mr. DAVY asked whether the pupil was mobile and the vision good.

Mr. CARTER found the mobility perfect, and the vision was good when the tissues of the eye were sound.

Mr. H. R. HARDY inquired whether Mr. Carter had tested the mobility of the iris by atropine, and what he thought of ether in eye operations.

Mr. CARTER had used atropine and fully dilated the pupil. As regarded ether, he had not found it relax the muscles sufficiently. Mr. Joy Jeffries, of America, had given ether with perfect success for him. At St. George's Hospital much ether was used. He had since used ether with satisfaction, and would not, if he could avoid it, return to chloroform.

Mr. RICHARD DAVY showed the pelvis of a man, æt. 43, who, having fallen ninety feet in May, 1871, died a few hours after of internal hæmorrhage. The left auricular facet of the sacrum was completely broken off and dislocated upwards with the left ilium, the symphysis end of the left ilium was half an inch higher than the right, but the osseous abrasion at this part was very slight. The left sacral margin and left lumbar transverse processes were roughly rasped off; the coccyx was pulverised, and the left femur simply comminuted, the right rami of the ischium and pubes were fractured on their pelvic aspect only. Mr. Davy mentioned that the sacro-iliac articulation preferred fracture of the sacrum to ligamentous separation, whereas the symphysis permitted dislocation. The sacrum had six vertebral coalescences.

Dr. ROUTH said he had known the sacro-iliac synchondroses separate in women after labour.

Mr. BRAINE asked whether these patients recovered.

Dr. ROUTH answered in the affirmative.

Mr. ROYES BELL showed a specimen of a tumour occupying the lower and inside part of the right forearm just above the wrists. On dissection it appeared to spring from the ulna artery and to involve the lower end of the ulnar bone; it was about the size of a

Tangerine orange, and projected in front and behind the forearm. There was ulceration where a puncture had been made in its anterior aspect; behind it was covered with skin, discoloured in places, and superficially ulcerated here and there. The specimen had been hardened in strong spirits so that it appeared firm, but at the time of operation it was clotted with blood. The patient from whom it had been removed was a woman, æt. 61, who had suffered from it for five years. Frequent hæmorrhage had taken place from the opening caused by a puncture in front. Its origin was attributed to a blow.

Mr. BRYANT thought it was a very uncommon specimen of a blood cyst, for the end of the ulnar had been partially absorbed. The whole subject of cysts in bone was of great interest. He related a case in point.

Mr. DAVY asked whether the limb should be removed summarily or an exploratory incision made.

Mr. BELL would also have preferred the exploratory incision if it had appeared desirable. On the whole, he and his colleagues thought amputation was demanded.

December 23rd, 1872.

THOMAS BRYANT, Esq., President, in the Chair.

Dr. BRUNTON showed a specimen illustrating

OSSIFICATION OF THE LONGITUDINAL SINUS AND MEMBRANES OF THE BRAIN.

There was also a slight patch of softening. The patient, a woman, died of fatty degeneration of the heart, at the age of twenty-seven.

Prof. ERASMUS WILSON said it would be interesting to know the use of the Pacchionian bodies. He could not understand the relation between diseases of those bodies and fatty degeneration of the heart.

Dr. WILTSHIRE thought it would be better to speak of such changes as Dr. Brunton found in the brain as calcification rather than ossification, seeing that there were no Haversian systems. He wished to ask whether the patient had borne children, and, if so,

how recently, and whether there was any disease of the coronary arteries of the heart.

Mr. STREETER would like to know how many times the patient had been pregnant. Rokitansky had shown there was an osteophytic deposit in the brain after every pregnancy.

Dr. BRUNTON had no intention of saying that degeneration of Pacchionian bodies was the cause of degeneration of the heart. The patient was delivered three weeks previously.

Prof. ERASMUS WILSON had gathered from Dr. Brunton that the patient was a teetotaller, and he thought such a person was not to be looked upon as necessarily healthy. Muscular substance was taken up, but replaced by inferior tissue, owing to malnutrition.

Dr. BRUNTON also showed a lad, æt. 19, who was the subject of

MORBUS CÆRULEUS.

He had blue lips, livid skin, occasional hæmoptysis, and ecchymosis; now and then he had palpitation.

The PRESIDENT related a case equally severe, which he thought illustrated the remarkable resistance of disease with which these patients were endowed. The patient, a young lady, æt. 22, had severe rheumatism with heart affection, from which she recovered perfectly, under the care of Dr. Herbert Davies.

Prof. WILSON said that reptiles were less obnoxious to inflammation than warmer blooded animals, and these persons partook somewhat of the character of such creatures as regarded their hearts. The nervous organisation of reptiles was also inferior.

Dr. CROMBIE showed

A NEW APPARATUS FOR THE SELF-ADMINISTRATION OF CHLOROFORM.

The PRESIDENT remarked that the apparatus was very like Dr. Junker's.

Mr. BELL did not think it was suited to operations.

Dr. FARQUHARSON thought the self-administration of chloroform was not desirable without the presence of a skilled person.

Mr. HENRY SMITH showed a specimen illustrating

PRIMARY EXCISION OF THE ELBOW-JOINT FOR INJURY.

The arteries and nerves were not involved, but the whole joint was so injured that he performed primary excision. He also showed

A PORTION OF BONE REMOVED BY TREPHINING FROM THE SKULL OF A MAN INJURED BY A HATCHET.

After a period of quiescent delirium, which was relieved by trephining, the man died. There had been bleeding from the ears, and at the post-mortem examination a fracture was found through the petrous portion of the temporal bone. A small quantity of blood was effused beneath the dura mater.

The PRESIDENT was glad to hear of the repetition of the operation of primary excision of the elbow-joint for injury. He had lately seen a man upon whom the operation had been performed thirty years ago, by Mr. Cock, where an excellent arm was preserved to the patient. He approved of the operation. With respect to the second case, injury to the skull added little risk to the operation, while the brain remained uninjured.

Mr. HENRY SMITH did not think so lightly of these injuries.

Mr. STREETER wished to know how he could tell there was a fissure in the cases that recovered.

Prof. WILSON thought the hæmorrhage from the ear was some evidence.

Dr. DOWSE related a case of fracture of the base of the skull in which there was hemiplegia, and in which recovery took place.

Prof. WILSON showed

TWO LOCKS OF HAIR, ONE WHITE AND ONE BLACK.

A lady, æt. 37, and pregnant, had a shock, after which all her hair fell off and she became bald for a year; then her hair came again but was quite white, and remained so three years; ultimately, it became dark again, and even blacker than before. The influence of the nervous system was well known. Perhaps, in this case, the change was intensified by pregnancy, in which condition the tissues were subject to important changes. It differed from cases of hereditary baldness. The influence of the nervous system was illustrated by jaundice occurring in three persons, one after the other; the second and third from seeing the first.

The PRESIDENT asked whether the eyebrows and lashes were

white, and was answered in the negative. How did Prof. Wilson account for the circumscription of the change to the hair of the scalp?

Prof. WILSON supposed the functions of the scalp were under more important nerves than other hairy parts of the body. The fifth was an important nerve and was more susceptible of influences. He mentioned a specimen in which the hair was brown and white in equal segments. It was inferred that the brown was grown in the day and the white in the night.

Mr. NELSON HARDY asked whether the lady wore artificial hair, as white hair grew beneath wigs.

Dr. BRUNTON asked what pathological change took place when the hair became grey in a night.

Mr. SPENCER WATSON was reminded of a case of a man whose hair had been white from a boy. He had a narrow escape from drowning, and after that his hair soon became white.

Prof. WILSON was convinced of the possibility of hair turning white in a night. The sudden introduction of air into the hair was believed to be the explanation of the phenomenon. Whether the air got in from without, or was secreted, he did not know.

Mr. HOGG did not think the air theory satisfactorily explained the phenomenon.

Prof. WILSON said there was no doubt that the air bubbles were in the hair and they acted as a curtain and hid the pigment. They could be seen by the microscope any day.

Mr. WM. ADAMS brought forward two cases illustrating the advantages of

GALVANISM IN THE EARLY STAGES OF INFANTILE PARALYSIS.

Mr. SPENCER WATSON asked to what particular parts the galvanism was applied: whether to the spine, nerves, or muscles?

Mr. WM. ADAMS answered by saying that galvanism was applied under water, both legs being placed under water in separate vessels, and then one pole was applied to each limb. After this each muscle was separately galvanised. He agreed generally with Sir Benjamin Brodie's remarks that if recovery did not take place within six months the case was almost hopeless.

The PRESIDENT still was of opinion that in some cases early galvanism was injurious. He had seen bad results from that

practice, and thought it should not be used under three or four months.

January 6th, 1873.

THOMAS BRYANT, Esq., President, in the Chair.

Mr. HENRY LEE, F.R.C.S., began his course of Lettsomian Lectures on Urethral Discharges. The first lecture was on

SYPHILITIC DISCHARGES,

and was published, with the succeeding ones, in the 'St. George's Hospital Reports,' vol. vi.

January 13th, 1873.

THOMAS BRYANT, Esq., President, in the Chair.

Dr. THOROWGOOD read some notes of a fatal case of

INTESTINAL OBSTRUCTION.

M. C—, æt. 60, was seen by Dr. Thorowgood on the evening of Monday, May 20th, 1872, with Dr. Wallace, of Hackney. The general health had been good up to five weeks previously, and on the 16th May he was seized with severe pains of a griping and twisting character. The bowels had been for several days without action; frequent enemata and purgatives failed to give any relief; recourse was had to opium, which relieved the pain. When seen on the 20th of May he had been a week without an action of the bowels, his face was flushed, pulse 88; tongue dry; frequent vomiting, but not of a stercoraceous nature; no jaundice; no passage of blood by bowels. Abdomen swelled and tense; a solid mass felt on right side.

A large injection was given by means of the gravitation tube; it passed easily into the bowel, and returned, bringing with it a few small pellets of fæcal matter. An ointment of mercury and belladonna was applied over the abdomen, and quarter-grain doses of

extract of belladonna were given every two hours. Seen again on the 24th. Tongue quite dry; pulse 88; urine scanty and turbid, and distress extreme. An injection containing extract of belladonna was given, and a pill as follows:

R Pulv. Opii, gr. $\frac{1}{4}$;
Ext. Belladonnæ, gr. $\frac{1}{4}$;
Plumbi Acetatis, gr. ss; horâ quâque secundâ.

After he had taken about ten pills the bowels acted freely with immense relief. On the 30th May he had four good consistent motions, and the mass on the right side got much smaller.

June 6th.—The obstruction appeared again with stercoraceous vomiting. For a time he got some relief by taking an aloetic pill three times a day, and the mass on the right side became scarcely perceptible, the bowels acting with loose motions under the influence of these pills.

Aug. 3rd.—He sunk and died quietly. The post-mortem was made the next day by Dr. Wallace, who was allowed to examine the abdomen only. The only morbid appearance found was extensive atheroma of the aorta and iliac arteries. No stricture or tumour was found involving the bowel, though the lower part of the small, and the whole of the large, intestine were carefully examined. The coat of the large intestine was wasted and thinned to a great degree. In commenting on this case, Dr. Thorowgood alluded to the importance of careful diagnosis; the rectum especially should be examined by the finger, and by a bougie or tube, to see if there be present one of those annular strictures high up which were described by Mr. Henry Smith in his Lettsomian Lectures in 1865.

The intense twisting pain at first seemed to point to a possible intussusception as the commencement of the trouble. To relieve this belladonna was tried, and this not succeeding, acetate of lead was added in the hope that as lead acts powerfully on the muscular coat of the bowel, so as to alter its calibre, it might in some way aid to untwist the invagination. One case was mentioned in which acetate of lead given thus had succeeded in affording relief, and in the present case after as much as five grains of the acetate had been given, copious relief followed. The bowels having been once opened, attempts were made to keep them open by enemata and stimulating purgatives; and though these succeeded so far as to remove the swelling on the right side of the abdomen, yet the patient sank and

died with all the symptoms during life, and appearances after death, of atony and wasting of the bowel. In reply to questions by Mr. de Meric and Dr. Wiltshire, Dr. Thorowgood thought latterly in the case galvanism after the method advised by Dr. Althaus might have been used with benefit. He did not himself see the patient later than June, but did not think galvanism was used during life. There was no evidence of heart disease. The mesenteric arteries were not examined, and Dr. Thorowgood had no theory to offer as to any casual connection of the atheroma of the aorta and iliacs with the atony of the bowel. In reply to Dr. Theodore Williams, Dr. Thorowgood said he gave the acetate of lead when all other means had failed, in the hope that it might, by acting on the muscular coat of the stomach, untwist the invagination; further, he had known the acetate of lead given in one case with conspicuous success. Dr. Wiltshire asked whether electricity would not have been useful. He cordially approved of treatment by means of opium and belladonna; but would not nux vomica or strychnia have been very useful in this case? He also asked whether there was any disease or plugging of the mesenteric arteries, especially of the parts of the bowels which were found to be thinned? What had become of the tumour felt during life? Was it a fæcal tumour due to paresis of the damaged bowel?

The PRESIDENT said many old people died from bowel disease, especially fæcal obstruction of the lower bowel. Many so-called cancer cases were of this kind. The intestine seemed to die first. He thought stimulating enemata were useful, and he had seen striking results from electricity. Were there not cases of obstinate constipation which justified opening the abdomen? He related a case of a severe kind in which colotomy was performed, the cæcum being opened and found to be empty. Afterwards some fæcal matter followed, and the patient got well with an artificial anus. Four years afterwards the wound was closed by operation, the lower bowel having been prepared for some days previously by injections. Such a case showed that circumstances did sometimes arise, which justified operation in cases of severe and prolonged constipation.

Dr. C. THEODORE WILLIAMS then read a paper on

THE VARIOUS MODES OF CONTRACTION OF CAVITIES IN PHTHISIS, AND THEIR RESULTS.

The author commenced by observing that it was very difficult to

foretell contraction of cavities, and remarked that when it took place the patient was by no means out of harm's way, for the contractile process might overstep the required bounds, and seriously obstruct respiration and circulation, causing death by dyspnoea and dropsy. Moreover, fresh diseases might arise in the other lung. Contraction of cavities, according to Dr. Williams's statistics of 1000 cases, occurred in six per cent. of patients in the third stage, and the void was filled in by one or other of the following means:—1st. By expansion of lung tissue around the cicatrix. 2nd. By an expansion and drawing over of the opposite lung to the affected side. 3rd. By displacement of the neighbouring organs, the heart, liver, stomach, and spleen. 4th. By collapse of the chest-walls. Dr. Williams then dwelt upon these modes of compensation, and explained the changes which the physical signs undergo during contraction, especially the increase of resonance over the former seat of the cavity and the shifting of the cavernous sounds to the posterior regions of the chest previous to their disappearance. This was owing to contraction always taking place towards a fixed point, which was generally the root of the lung, but not necessarily so, as it might be some spot where the pleura was strongly adherent. A contracting cavity of the left lung, as a rule, caused more displacement of organs than one of the right. When the cavity was in the right lung, the liver might be raised, the left lung drawn across, and the heart considerably displaced upwards, outwards, and in the direction of the right axillary region, which it sometimes approached. When the cavity was in the left lung, the heart was drawn upwards and towards the left axilla, the apex often describing the arc of a circle of which some point in the neighbourhood of the aortic valves was the centre; the stomach was raised and could be detected by its characteristic note as high as the fifth rib; the left lung itself was so much contracted that the heart's movements were visible in the second and third interspaces, and the right lung was drawn across the median line. Collapse of the chest-wall generally took place in all cases of contracted cavity, but often at a late date, the expansion of the healthy lung and the displacement of organs, particularly the abdominal, sufficing to fill the void for some time. Several cases were given to illustrate these points. The author then drew attention to the various periods required for contraction of a cavity in these cases. In some it took place in two months, in others it occupied two years, the size of the cavity being no index of its rate of contraction.

The results of the process on the general health of the patient were then considered, and it was pointed out that in some patients the contractile process caused so much obstruction to the respiration and circulation as to create great and increasing dyspnœa, irregular action of the heart, and eventually death. Another termination was by albuminuria and dropsy, and the few kidneys examined after death showed signs of degeneration.

Dr. THOROWGOOD agreed with Dr. Williams that more attention ought to be paid to the phenomena of contraction of cavities. He thought it occasionally followed symptoms of inflammatory action. He would like to hear more as to the best means of promoting the contraction of a lung cavity.

Dr. SANSOM's experience went with Dr. Thorowgood, that contraction often followed evidence of local irritation, and he thought perhaps it might be well to induce such a process. Acupuncture might possibly be justifiable.

Dr. WILLIAMS, in reply, said he knew of no means of promoting contraction of cavities, but he had found endeavouring to improve the patient's health and strength and allaying local irritation to be the best course to pursue. He could not agree with Dr. Sansom that the induction of a state of hyperæmia was advisable, and he should hesitate about the use of acupuncture of the lung, although Dr. Dieulafoy had shown it to be less dangerous than was supposed. With regard to cavities being more likely to contract in one kind of phthisis than in another his impression was that this was the case in phthisis of pleuro-pneumonic origin. He had not found that intercurrent inflammation assisted the contractile process, but rather the reverse.

January 20th, 1873.

THOMAS BRYANT, Esq., President, in the Chair.

Mr. HENRY LEE, F.R.C.S., delivered his second Lettsomian Lecture, the subject of which was

PROSTATIC DISCHARGES.*

* Published in the 'St. George's Hospital Reports,' vol. vi.

January 27th, 1873.

THOMAS BRYANT, Esq., President, in the Chair.

MR. THOMAS HARVEY HILL asked leave to make some remarks with reference to Dr. Thorowgood's treatment of obstruction of the bowels. Since the last meeting he had suggested the use of acetate of lead in combination with belladonna, in a case of obstruction, and in twelve hours there was a profuse action of the bowel, with complete relief.

Dr. SANSOM showed a patient who had been the subject of

EXTRA-THORACIC SUPPURATION, WITH DISCHARGE INTO THE LUNG.

R. B—, æt. 37, applied at the Royal Hospital for Diseases of the Chest, as an out-patient, on Nov. 1, 1872, suffering from debility and cough, with expectoration of much thick phlegm. Four years ago she had a miscarriage, and had never been well since, extreme languor and shortness of breath succeeded any exertion, and six weeks before her admission she noticed a swelling above the right collar-bone, recurring after a violent cough. Auscultation and percussion failed to elicit any evidence of general pulmonary lesion; but above the right clavicle there were obscure cavity sounds; close to their situation was a limited oval swelling, evidently glandular; and below the clavicle a diffuse fulness was noted. The patient was admitted on the 4th. The glandular swelling was now tender and painful, and throbbings were experienced in the infra-clavicular fulness. Dr. Sansom did not consider the cavity (which was evidently of very small extent) in the right apex, tubercular. The patient presented no phthisical sign; the cough was violently paroxysmal, and it was quite clear that for long periods it had remained in complete abeyance. He was disposed to think the occasional large *râles*, and amphoric sounds heard above the clavicle, due to a dilated bronchus or ruptured air-cell. He considered that suppuration was taking place in or around the inflamed gland. Under rest and emulcents and expectorants the cough and expectoration entirely ceased after four days, but the local tenderness

increased and became exquisite. Liniment of iodine was applied but could not be borne.

Nov. 22nd.—Deep fluctuation was noticed over the swelling. Poultices were adopted, and iron and quinine administered.

On the 6th Dec. suddenly occurred the expectoration of half a pint of pus, the cough being accompanied by a peculiar rattling felt, as well as heard, in the supra-clavicular region. Swelling had to a great extent subsided. Auscultation revealed gurgling, with a crackling sound on coughing, and pressure of the finger produced a feeling of large crepitation.

On Dec. 21st all swelling had subsided as well as all the signs and sounds, and tenderness had almost gone.

On the 10th Jan., 1873, fluctuation and tenderness were again manifested as previously, and on the 17th occurred a second copious expectoration of pus. The patient, who was still under care, suffered yet from severe cough, with occasional expectoration of rather foetid purulent phlegm; the supra-clavicular prominence had largely subsided, but the finger still readily detected the crackling sensation produced by a cough, and gurgling was still heard. Over all the rest of the thorax the sounds were quite normal.

Dr. SEMPLE thought there was a large gland pressing upon the subclavian artery.

Dr. THEODORE WILLIAMS would have said there was a suppurating cavity, had he not heard the history of the case; probably there was an abscess which had broken into the lung tissue.

Dr. SANSOM said that against the hypothesis of phthisis, the facts of absence of phthisical prodromata, the persistence of fair weight and the existence of menorrhagia were important; physically, the signs were those of cavities.

Mr. ROYES BELL asked if there were rigors, and whether the temperature was high?

Dr. J. MILNER FOTHERGILL remembered a case in which a fluctuating tumour appeared over a man's loins. Soon after, violent coughing ensued, and expectoration of enormous quantities of pus. It was evident that the lumbar abscess communicated with the lung. The man recovered after a like occurrence on the other side of the loins.

Dr. HABERSHON then read three instances of

AORTIC DISEASE

which had recently come under his care, and showed the pathological specimens. The first was that of a man, æt. 39, who had suffered from repeated attacks of rheumatism. When admitted into Guy's Hospital, in August, 1872, he was suffering from urgent dyspnœa and cardiac distress, with œdema of the lower extremities; a loud double bruit was audible over the aortic valves, and in the course of the aorta, but after a few days the bruit changed in character, and became a continuous sound. He died on the 10th September, and on inspection the aortic valves were found to be extensively diseased, one was contracted and everted; the valve nearest the pulmonary artery was thickened, ulcerated, and covered with fibrinous vegetation; an ulcerated opening immediately above the valve extended into the pulmonary artery, the edges were irregular, and the opening was partially blocked up by fibrin. The mitral was thickened, but other structures were healthy. Dr. Habershon referred the changed character of the sound to the ulcerative communication between the aorta and the pulmonary artery. The *second* case was that of a man, æt. 56, who was brought to the hospital in a dying state, in December, 1872; he had been engaged in labourer's work, and dated his last illness to a cold taken at Christmas, 1871; dysphagia came on two months before death, and gradually increased in severity. The patient suffered from dyspnœa and severe pain between the shoulders; a short systolic bruit was audible at the apex of the heart. The prostration was extreme when he was admitted. The aorta was found to be much diseased, especially in the ascending and transverse portions, and the vessel was so enormously dilated as to admit a man's fist. On the right side, immediately above the valves, a pouch extended to the right, and the lung in contact with it was sloughing. Other lobules of the lungs were in a similar state. At the commencement of the ascending aorta an angle was formed by the contraction of the pouch, and at this part pressure had been made upon the left bronchus and upon the œsophagus; an oval communication, an inch in length, existed between the two canals, and the ends of the bronchial cartilages projected into the œsophagus. The *third* instance was a very remarkable one, in which multilocular aneurysm of the ascending portion of the arch of the aorta existed. The sac extended behind the sternum, and occupied the normal position of the heart; it perforated the ribs, and a third false sac formed a pulsating tumour extending from the left side of the sternum below the left nipple, in

the direction of the axilla. Death resulted from the perforation of the post-sternal sac into the left pleura. The patient was 55 years of age; he dated his illness from a blow on the chest, and afterwards he suffered from pain about the left breast, especially on exertion. The attacks became more frequent during the last year of his life, and three weeks before admission into the hospital, at the end of October, 1872, he noticed a swelling in the præcordial region. This swelling rapidly increased in size, and became as large as both fists, and pulsatile in character. Darting pains came on, with dyspnœa and distress, and when hæmorrhage into the pleura occurred, he speedily sank. The aorta was found to be dilated and atheromatous, and two inches above the valves was an opening three inches in circumference, which passed into an aneurismal sac and then into the subcutaneous sac, the latter opening being between the third and fourth ribs. Forty ounces of clot and much serum were found in the left pleura. The question of differential diagnosis between aneurismal and vascular malignant growth was briefly dwelt on, but the result showed the original opinion of aneurismal disease to have been correct.

The PRESIDENT asked whether, in the third case, a mistake might not have arisen between it and pulsating tumour of bone. Could Dr. Habershon give any means of diagnosis between such cases?

Dr. HABERSHON thought the question of differential diagnosis of aneurismal disease one of great importance, and it had specially arisen in the second case. In the third case the dulness was more defined than in most tumours of the chest.

Dr. BROADBENT thought that thanks were due to Dr. Habershon for his excellent cases, and would ask whether in the first case the opening into the pulmonary artery was congenital. The right ventricle was very small, and gave rise to the thought. Then again, if there was ulcerative endocarditis, it was ill marked. The pulmonary artery was small also. He thought the opening was congenital, and that the left ventricle had supplied both general system and lungs for a great part of the patient's life.

Dr. ROUTH asked whether Dr. Habershon attributed the change in sounds to sudden disease; if so, it did away with Dr. Broadbent's hypothesis.

Dr. SEMPLE thought Dr. Broadbent's a very reasonable explanation; ulcerative endocarditis was extremely rare.

Dr. HABERSHON thought Dr. Broadbent's explanation was very

interesting, but the case was supposed not to be congenital, because a systolic and diastolic bruit was heard, which afterwards changed to a continuous blowing murmur. He thought ulcerative endocarditis was not very uncommon.

Dr. THEODORE WILLIAMS then showed a patient illustrating

TAPPING FOR EMPHYEMA.

The patient, a man, æt. 29, was admitted into the Hospital for Consumption, at Brompton, on the 4th of July, 1871, with a history of pleurisy of four and a half months' standing, and with signs of extensive effusion into the right pleura. The right side measured one and a half inches through the mammary region, more than the left. The dyspnœa was great and the pulse rapid.

On the 10th of July he was tapped by Sir William Fergusson, and four pints of purulent fluid were taken away with temporary relief, but fresh accumulation took place, and an abscess formed in the mammary region, which was opened by Mr. Bartlett, and found to communicate with the pleura, through a channel passing between the two layers of intercostal muscles, which acted as a valve, preventing the entry of air. In spite of this mode of exit, the matter rapidly accumulated, the valve was rendered insufficient, air was admitted, and the discharge became offensive. The patient became much worse, and began to show symptoms of pyæmia.

On the 21st of August Mr. Henry Smith made a second opening in the posterior wall of the chest, and passed a seton through; this greatly increased the discharge, and also its offensive odour. On the 24th, at the request of Dr. Williams, Mr. Henry Smith introduced a drainage tube, and injected a solution of carbolic acid into the pleura. The effect of this was that the discharge became serous, small in amount, and free from smell; the pyrexia immediately disappeared, and the man made a rapid recovery. The lung had quite resumed its former position, and the patient had been able to return to work. Dr. Williams strongly recommended the use of the drainage tube in cases of pyæmia, and especially if rapid formation of pus took place.

Dr. Habershon, Dr. Douglas Powell, Dr. Sansom, Dr. Wiltshire, and Mr. Royes Bell, took part in the discussion which followed, to which Dr. Williams briefly replied.

February 3rd, 1873.

THOMAS BRYANT, Esq., President, in the Chair.

Mr. HENRY LEE, F.R.C.S., delivered his third and last Lettsonian Lecture on Urethral Discharges, the subject of which was

DIFFERENT NON-SYPHILITIC DISCHARGES.*

At the conclusion of the lecture a vote of thanks was unanimously accorded to Mr. Henry Lee for his admirable lectures, and he was requested by the Society to publish them.

February 10th, 1873.

THOMAS BRYANT, Esq., President, in the Chair.

The PRESIDENT exhibited a drawing of a case of

PERIOSTEAL SARCOMA OF THE LOWER JAW.

The operation for removal was not difficult, but it was found necessary to disarticulate the jaw. The periosteum was separated, and the whole bone was taken out with great facility. At the end of five weeks the patient could masticate, and new bone was found to have been formed. The President also showed drawings of a case of

IVORY BONE GROWTH OF THE ORBIT.

The patient was brought before the Society a few weeks ago. Mr. Bryant operated without difficulty, and removed a large mass of bone from the right orbit and frontal sinus. The patient had done well.

Mr. JABEZ HOGG asked whether it would not have been best to let the orbit alone in this case?

* Published in the 'St. George's Hospital Reports,' vol. vi.

Mr. BRYANT agreed that, had he known the exact state of the parts beforehand, he thought he would not have invaded the orbit. He thought the eye had been lost by not having stitched the eyelids, which he would do if another case offered.

Mr. HENRY SMITH then read a paper on the treatment of

HÆMORRHOIDS AND PROLAPSUS OF THE RECTUM
BY THE CLAMP AND CAUTERY, WITH THE RE-
SULTS FURNISHED BY 300 CASES AND UPWARDS.

He commenced by referring to the first recorded cases of the treatment in question which were given to the Profession in the Lettsomian Lectures delivered before the Fellows in 1855. At that time the cases he had operated upon were only thirty-eight, but the results of these induced him to continue the treatment; as his experience increased, he gradually began to discard the use of the ligature, and he finally gave it up altogether, partly in consequence of some disastrous results in his hands, and partly from the excellent experience of the clamp and cautery. He now had operated on upwards of 300 cases, and many of them of the most severe and formidable character both locally and generally, and he would lay fairly before the Society the results of his extensive experience. He would first refer to some of the objections which had been made against the treatment in question, some of which were quite frivolous, such a one for instance as had been urged against it by a well-known writer on diseases of the rectum, who affirmed that the operation was bad because more than an hour was consumed in performing it, the truth being that five, ten, or fifteen minutes were ample, as far as the actual operation was concerned, according to the nature and magnitude of the disease. As regards the mortality which had occurred in his hands, he had already laid before the Profession two instances where death had taken place after the operation, and since that period a third fatal case had occurred in the instance of a gentleman in broken-down health, on whom he had performed a somewhat severe operation. Severe vomiting set in and continued for thirty-six hours, and then intense jaundice followed, the patient dying on the fifth day. There was no post-mortem examination; and thus it was impossible to say whether death was caused by the chloroform or from some latent liver disease which had been aroused into activity by the operation. Only in two instances had anything like severe constitutional dis-

turbance arisen after the operation. With reference to hæmorrhage, which was pronounced by some as a grave objection to the operation, he had not met with one single case where he had to plug the rectum, and only one instance where it was necessary to inject iced water. The immunity from bleeding he considered to be due to the great care with which he applied the cautery, using it very freely and with instruments of various shapes and sizes. He had never seen ulceration occur and persist for any length of time after the operation in any single case in his practice. The period of convalescence was short ; in the majority of his cases the patients were walking about in a week. He had never known erysipelas or secondary abscess to occur after operation, a condition which occasionally gave great trouble after the use of the ligature, and the pain which ensued was generally at an end after two or three hours. The author then made some special observations regarding the mechanism of the instruments he used. Above all things it was most necessary that the blades of the clamp should have a perfect parallelism when they closed, and it was very important after the cautery had been applied, to unscrew the blades very gradually in case any vessel should have escaped the influence of the cautery. There existed considerable difference of opinion as to the value of the non-conducting plates of ivory attached to the clamp, but he never thought of operating without them, and if the patient did not take chloroform they were absolutely necessary, as they entirely prevented the pain of the cautery. In corroboration of his remarks as to the absence of bleeding and other points to which he had referred, Mr. Smith read letters from several of the old house surgeons of King's College Hospital, all of whom spoke as to the absence of bleeding in the cases they had attended.

In the discussion which followed,

Mr. BOND said that when at King's he had seen both cautery and ligature used, and had left without any decided opinion on the subject. Subsequently, a case of a severe kind came under his notice, which had been treated by the cautery with great success. He had since then used the cautery in fifty cases very successfully and without hæmorrhage. He only used cautery in severe cases, preferring ligature in simple cases. He never used the clamp without giving chloroform, and thought the ivory appendages were of no use. He preferred the clamp for prolapsus ani, and for some operations about the nymphæ.

Dr. VINE defended the ivory bars which he had invented. Ivory was a non-conductor, and prevented burning of adjacent tissues by conduction or from slipping of the cautery.

Mr. ALLINGHAM congratulated Mr. Smith on his success. He thought the clamp and cautery a good method of operation, but that the ligature, used as it ought to be, was a better. In 3000 cases operated on at St. Mark's Hospital by ligature not one case of pyæmia occurred, and tetanus in one case only. He had not had a single death in 500 cases operated on by ligature by himself. As regarded hæmorrhage, perhaps, he had not at first applied the cautery so freely as Mr. Smith had, but of late he had used the iron freely, and had had no hæmorrhage. If patients were sent out too soon after the use of the clamp and cautery, severe ulceration ensued inevitably. The susceptibilities of patients to pain differed greatly, but he thought there was no more pain after ligature than after the clamp. He thought the ivory wings of the clamp too broad and prevented the due removal of sufficient tissue. Free removal was absolutely necessary, and the pile should be removed down to the cellular tissue if a radical result was aimed at.

Mr. ALFRED COOPER had had a great number of cases of hæmorrhoids under his care, and had used the ligature and the clamp about equally. He had never any reason to be dissatisfied with the ligature, but with the clamp he got severe secondary ulceration, and much greater pain was caused by the clamp than by the ligature. He had never seen hæmorrhage after the ligature; he could not understand how a patient could be cured effectually after three or four days. The plan of ligature introduced by Mr. Salmon, at St. Mark's, answered admirably.

Mr. DUNN corroborated Mr. Smith's statement as to the case they had seen together. The patient had been under the care of several eminent surgeons, who declined to operate. He thought, however, the plan of ligature at St. Mark's was excellent.

Mr. DAVY drew attention to Ambrose Paré's directions for avoiding the burning of skin. He thought the ivory was useful, for the instrument often slipped when grasping the pile.

Mr. WM. ADAMS asked whether, with reference to the ulceration, it might not be caused by using too hot an iron or by constitutional causes. The *écraseur* had given him satisfactory results in cases of disease of the rectum.

Mr. WIBLIN, of Southampton, as a provincial Fellow, had listened

to the paper and the subsequent discussion with much pleasure. In his earlier years he had used the ligature, but of late he had used the clamp, which he much preferred, as causing less pain, and out of thirty-eight carefully recorded cases he got excellent results and had never had any hæmorrhage. He had not himself observed ulceration, and had been surprised at the rapidity of recovery.

The PRESIDENT had for many years dealt with piles by means of ligature; for the last eight years he had used the clamp and cautery, and had been well pleased with the results. He thought the iron should be freely used. The clamp was only a means to an end, and the treatment should be spoken of as by cautery rather than as by clamp. He always clamped each of the diseased portions before using the iron. The galvanic cautery answered admirably.

In replying, Mr. HENRY SMITH thanked the Fellows for the kind manner in which they had received and discussed his paper. He agreed with the President that the cautery was the principal part of the operation; it should be applied at a black heat. If there had been so much ulceration as had been spoken of, surely he would have heard of it, but as a matter of fact he had not heard of it. Mr. Allingham's remarks were valuable. As regarded pain, except in a very few cases, he had not met with it, and this he attributed to the ivory plates, for which suggestion he had to thank Dr. Vine.

February 17th, 1873.

THOMAS BRYANT, Esq., President, in the Chair.

Mr. BOND showed a case of

EXCISION OF THE METATARSAL BONE OF THE GREAT TOE.

He removed a portion of bone, but did not interfere with the phalangeal articulation; the patient, who had but one leg, could walk well now.

Mr. ROYES BELL thought Mr. Bond had made a capital job of a bad case, the foot was useful and shapely.

The PRESIDENT concurred, and thought the case opened the

question whether it was not better to leave one articular facet of the joints in excision of bone. He mentioned a similar case in the hand, which had resulted in an excellent thumb.

Mr. HENRY SMITH showed a

DISEASED TESTICLE REMOVED FROM A MIDDLE-AGED MAN, THE SUBJECT OF CHRONIC ENLARGEMENT OF TESTICLE, AND HYDROCELE.

Thinking it was scrofulous, Mr. Smith treated the patient constitutionally and tapped the hydrocele, putting in a seton; subsequently suppuration and fungus occurred; for this castration was ultimately performed. He had used the hæmorrhoidal clamp and cautery with great success, no hæmorrhage having occurred either at the operation or subsequently to it.

Dr. FAYRER was pleased with the operation which he had witnessed. His own experience in India, which was large, had convinced him that there was little cause for dread of hæmorrhage from the spermatic artery; he thought the withdrawal of the cord within the inguinal canal was a bugbear. He was well pleased with the use of the clamp and cautery as in hæmorrhoids.

Dr. J. T. DICKSON showed a new truss covered with green elastic, which prevented rusting, and rendered it extremely durable.

After some remarks by Mr. ROYES BELL, Dr. FAYRER, and the PRESIDENT,

Dr. DICKSON read a paper on a case of

TREPHINING IN EPILEPSY.

The patient was brought forward, and in the discussion which followed,

Mr. HENRY SMITH asked what was the condition of the bones and membranes?

The PRESIDENT, as the operator in this case, said that there was pain in the original seat of injury, and he removed a piece of bone the size of a shilling, which was thought to be denser than natural; there was no evidence of fissure or of disease of the membranes of the brain. The boy's aspect, which before the operation was that of an epileptic, had wonderfully improved. He had trephined in a case of epilepsy from syphilis with the best results. Sir Astley Cooper had said that he had never regretted interfering with bone in cases of fracture of the skull with depressed bone, but had regretted leaving such cases alone.

Mr. M. DONAGH questioned whether medicines might not remove growths, as trephining was so serious an operation. He related a case of epilepsy, which followed a blow on the head, with depressed bone, which yielded to a mild mercurial course.

Mr. HENRY SMITH asked what evidence there was that the mercury acted as an absorbent? he doubted whether bone was absorbed by mercury.

Mr. WILLIAM ADAMS said that mercury might lower the circulation, and the brain become adapted to the depressed bone. Stromeyer resorted to antimony in these cases with benefit.

Mr. TEEVAN said that some years ago he drew the attention of the Profession to the operation of trephining in cases of traumatic epilepsy. He related a case in point, and cordially approved of the operation in suitable cases. He thought that in such cases there was detachment of the internal table of the skull.

Dr. J. MILNER FOTHERGILL thought that the case well illustrated Romberg's views; he suggested that in diseases of this character search should be made for evidence of traumatic injury. Agents affecting the circulation of the blood in the brain might have influence in these cases.

Mr. DALBY mentioned a case of suppurating wound of the bones of the skull in which epilepsy was cured by trephining.

Dr. DICKSON said, epilepsy was not produced by plethora in the brain, but by anæmia consequent upon spasm of the arterioles. Adaptation of brain to injured skull was rare. If epilepsy was periodically recurrent there was reason for interference. Absorbents, as bichloride of mercury, made no permanent impression.

Mr. PENNEFATHER showed an instrument for examining the ears when daylight was not available; it consisted of a lamp, two reflecting mirrors and a series of lenses, adapted to an enlarged Kramer's dilating speculum, which enabled the surgeon to examine the ears thoroughly at any time.

Dr. PETER ALLEN preferred Brunton's instrument, with a little modification of his own, for examining the ear by daylight. If the operator used a mirror with a frontal bandage he could regulate the light. He thought the instrument shown by Mr. Pennefather was a good one.

Mr. PENNEFATHER claimed for his instrument the power of dilatation, which was essential in many cases.

Mr. ROYES BELL had used Mr. Pennefather's instrument with great advantage in a case of foreign body in the ear.

Mr. NELSON HARDY brought forward a case of frontal anæsthesia and loss of parallelism between the eyes, caused by the presence of two pieces of glass within the orbit. The patient was shown.

February 24th, 1873.

THOMAS BRYANT, Esq., President, in the Chair.

Mr. W. F. TEEVAN read a paper on

IRRITABLE BLADDER.

The author commenced by stating that one of the most common causes of irritable bladder was incipient stricture, which was but rarely diagnosed, because it might exist and yet permit a full-sized catheter to be passed with ease without the slightest contraction being discovered. The urethra might practically be regarded as a funnel-shaped tube, the meatus externus being the narrowest part. Hence, as the deeper portion of the canal was fully double the calibre of the external orifice, it followed that no English instrument could diagnose incipient stricture; for when it was employed, sensation was distributed all over, equally, but it was otherwise with the French bougie à boule (ball staff), which could detect the slightest indication of a stricture, inasmuch as the sharp shoulder of the ball would, when the instrument was being withdrawn, catch at the slightest contraction and be thus arrested in its progress. A No. 12 English instrument might be passed and no contraction felt, and yet a bougie à boule, with a head only half the size in diameter of the former, would immediately detect any contraction, as the urethra was not patent like a gas-pipe, but in a state of collapse, so that the mucous membrane was in contact with an instrument, however small it might be. It constantly happened that there was no relation between the severity of a stricture and the annoyance resulting from it, for one patient might have a stream no bigger than a fine probe and suffer no inconvenience, whilst another would pass a large stream and yet be troubled by

incessant calls to urinate. The cases related by Mr. Teevan were those of patients who had been obliged to give up their occupation through being troubled with frequent micturition, and incipient strictures were in all cases detected by the bougie à boule.

The PRESIDENT thought the Society was indebted to Mr. Teevan for his paper. It should not be supposed that a man had no stricture because an ordinary full-sized catheter could be passed. No surgeon should allow a case of irritable bladder to be long under his care without passing an instrument to ascertain whether the patient had a stricture, since that was frequently a cause of irritability. Gradual dilatation was most efficient and safe. Mr. Teevan's cases were illustrative types. In all cases of chronic gleet, examination for contraction should be made, since in a great number of such cases stricture existed. How did Mr. Teevan dilate?

Mr. TEEVAN almost always used the Olivary bougie, leaving it in three to five minutes. This he did once a week, having found too frequent interference harmful. He would like to know the experience of the Fellows as to the *cure* of stricture; he himself doubted it.

The PRESIDENT thought there could be no question, pathologically, that stricture could not be cured, or only exceptionally so. He related a case in point in which a cure appeared to result from Syme's operation performed fifteen years ago. The patient came to him every three months and was always found to be well.

Mr. ROYES BELL said that at King's College Hospital dilatation was the mode chiefly pursued. He related a severe case which had been under his care, and which, after many years' suffering and three incisions, yielded to gradual dilatation.

Dr. J. MILNER FOTHERGILL asked how the irritability of the bladder arose in these cases? he could understand it in many other cases, but not in these.

Mr. BRAINE asked what was the longest time the Fellows had known an instrument left in the bladder? He knew a young gentleman who had had a catheter in his bladder day and night for five years.

Dr. BRAXTON HICKS said that in cases of contracted vagina he found that after scratching or slightly incising the indurated tissue the cicatrices disappeared, and he related cases in point.

Dr. WILTSHIRE asked what effect syphilis had on the various kinds of urethral, vaginal, and rectal structures.

Dr. SEU, of New York, said he had seen a case of traumatic stricture of the vagina under the care of Carl Braun, in Vienna. In this case no good result followed dilatation. He was much interested in Mr. Teevan's cases, and had met with similar. The Olivary bougie was now essential in the treatment of stricture.

Mr. TEEVAN, in reply, said that he thought it was a want of expansion of the urethra which gave rise to back flow into the bladder and excited to increased action. He agreed with M. Mercier that if incision was thought necessary it should be done with a double-edged urethrotome, so that a symmetrical urethra should result. He did not like leaving instruments in the bladder.

Mr. ROYES BELL (for Mr. Bartlett) related a case of

PHTHISIS ; PROFUSE HÆMOPTYSIS AND STRANGULATED HERNIA.

W. B—, æt. 39, was admitted into the Hospital for Consumption, under the care of Dr. Pollock, 11th October, 1869, in an advanced stage of consumption. Under treatment he improved, and various attempts were made to reduce the hernia without success, and on the 12th December Mr. Royes Bell performed the usual operation, from which he recovered completely within ten days; the other signs, however, grew worse, and the man died on the 15th January, 1870. At the post-mortem the body was found much emaciated. The left pleura firmly adherent throughout; right pleura adherent at apex. Right lung at apex contained a large vomica with irregular walls, the rest of the lung, on section, presented yellow patches of cheesy matter surrounded by pneumonic consolidation; left lung showed, at apex, a small cavity, and throughout the rest of the lung were patches of yellow tubercle. The wound was perfectly healed.

Dr. BLOXAM had once been called upon to operate for strangulated femoral hernia in three cases in six weeks. They all got well; but one case presented adhesion of omentum and great hæmorrhage. Some time after a piece of whipcord which was used came away. He should treat omentum with much respect in future, but would be inclined to remove any portion that looked amiss.

The PRESIDENT thought it best to remove omentum if it was met with in large masses. He would in future use carbolised catgut ligatures in such cases, and cut them short. He had been often struck with the rapidity of the recovery made by patients after hernial operations, even when suffering from far-advanced organic diseases.

March 3rd, 1873.

THOMAS BRYANT, Esq., President, in the Chair.

Dr. SABBEN read a paper upon the

FORCIBLE FEEDING OF THE INSANE.

After stating his reasons for bringing the subject before the Society, he went on to show the importance of the adoption of some means of forcible feeding by members of the Medical Profession generally, on the ground that it was, in most cases of insanity, most detrimental to the patient and most unfair to the medical psychologist, who had to undertake the after-treatment of the case, to allow the insane to abstain long from food. He then proceeded to criticise the papers which had recently appeared in various medical journals, especially those of Dr. Anderson Money and Dr. Duckworth Williams. Having done so, he went on to describe the process of feeding which is in use in the West Riding Lunatic Asylum, and gave interesting and detailed accounts of four cases in which he had himself witnessed the forcible administration of food, and maintained that nothing could be more easy, expeditious, and safe than the method of feeding by the funnel and œsophageal tube, which is practised in that asylum. He also quoted from Dr. Crichton Browne some statistics as to the numbers of patients fed in that asylum in the course of the year, and stated that gentleman's opinion, to which he properly attached great weight, that the system as there employed left nothing to be desired, and that in his long experience no accident had ever taken place in connection with the use of the œsophageal tube more serious than the breaking of a tooth. Dr. Sabben then proceeded to consider the method, which is so strenuously advocated by some medical men, of feeding through the nose. He examined and commented on Dr. Tuke's papers in the 'Journal of Mental Science,' and gave him the credit of having introduced that method, which was undoubtedly of much use in many cases. He had not, however, a very large experience of the use of the nasal tube. He could not agree with one of the correspondents of a weekly medical journal who has recommended

choking as a preliminary to feeding or as a means of getting the patient to open his mouth to admit of the passage of the tube, and advised that gentleman to have recourse to the use of nasal feeding by means of a spoon. He then proceeded to explain the method of forcible feeding which he has used in his asylum and practice with perfectly satisfactory results; at the same time he did not claim the merit of any originality in the matter, for the method of feeding by means of the spoon might have been used by many other medical men. He described minutely how the patient should be placed and held, and how the food, which was to be slightly heated, was to be poured into one nostril while the other was compressed by the fingers of the operator. Thus administered the food must be swallowed, and he had never seen coughing or sneezing result. The patient's mouth was left free so that there was no interference with respiration. He advocated this method as well upon physiological as upon moral grounds in certain cases, and pointed out that it had one great recommendation, and that was, that it did not require the possession of any great amount of skill, and could be readily performed by an attendant or nurse when it was impossible to procure medical aid. He then detailed some very interesting cases in which he had used this method, and in which the results had been eminently satisfactory. He advocated its adoption by medical men in four classes of cases:—1, where it is impossible to open the jaw without injury to the teeth or gums; 2, where long abstinence has existed; 3, where delusions are present as to the power of swallowing; 4, where there is great irritability of the stomach and where vomiting occurs. He exhibited a great variety of the instruments of forcible feeding which were formerly used in lunatic asylums, as well as those which are had recourse to in various hospitals for the insane at the present time.

The PRESIDENT said, he had used nasal feeding by means of a tube in cases of cut throat and other accidents with much benefit.

Dr. SANSOM asked whether any difficulty had been found with the hairs in nasal feeding? In experiments on the administration of anæsthetics by the nose in operations on the mouth he found that there was often difficulty in breathing through one nostril. Had Dr. Sabben ever given chloroform to his patients, and then offered them food as they recovered consciousness?

Dr. TUKE coincided with Dr. Sabben's views, and was glad he had brought the subject before a general rather than a special society, as

he thought exclusion should be broken down. He preferred generally the nasal tube, the spoon feeding by the nose being only suitable to quiet patients. He thought the stomach pump and the nasal tube were both useful, but he preferred the latter.

Dr. LEARED related a case of severe ulceration of the larynx in which feeding by the nasal tube was attended by disagreeable results. He would ask what relation Dr. Sabben's plan of feeding through the nose by a spoon bore to Dr. Thudichum's plan of washing out the nostril?

Mr. NAPIER suggested that the top of the lever used for opening the mouth should be covered with ivory, to prevent injury to the enamel.

Dr. BOYD had been in the habit of using the stomach pump for many years, but having had a disagreeable result he adopted the use of an instrument which he showed. He placed the patient in a chair, and had the head held by a steady attendant. He thought feeding could be done without much force, and questioned the desirability of giving chloroform to patients as feeble as these generally were.

Mr. BALFOUR BROWNE, barrister-at-law, thought it was a matter of importance that the Medical Profession should arrive at some conclusion as to the best method of forcibly feeding the insane. The less violence used was of course the better.

Mr. DAVY thought the gag was a cruel machine, and that its use should be avoided as much as possible. The nasal tube was much to be preferred, as it enabled the operator to dispense with such instruments.

Dr. SABBEN, in reply, said he would not give chloroform to these patients. The nasal tube could generally be used in skilled hands; but when there was anæsthesia of the passages the tube might get into the wrong place. He had never seen food return when given through the nose with a spoon. He had never seen regurgitation through the nose.

The PRESIDENT exhibited a large tumour of the breast, weighing 5 lb., which he removed from a lady seventy years of age. The tumour had been growing for twelve years, and rapidly of late; it was found to be a case of cystic sarcoma; there were intra-cystic growths characteristic of simple cystic disease. He had used animal sutures, and the case had done well. There was no discharge from

the nipple, showing that it was not a true cystic disease of the breast.

Dr. R. J. LEE showed a

SPECIMEN OF ANEURYSM,

and mentioned more particularly the fact that the left recurrent nerve was implicated in the tumour, and that although the laryngeal branches appeared to be in a natural condition, the nerve structure was destroyed in the inferior part of the main trunk. Another specimen was exhibited in which the right recurrent nerve, in a fatal case of innominate aneurysm, was shown side by side with the healthy nerve, and the extent to which the nerve-tissue may be destroyed was clearly seen. Dr. Lee also stated that in cases of aneurysm in which a bruit could be heard it would be found on post-mortem examination that the walls of the aneurysmal sac contained more or less calcareous matter, and that the absence of a bruit was evidence of that condition of degeneration of the arterial wall, which depended on pathological changes in the middle coat unaccompanied by cretaceous deposit. The general principle was maintained that all morbid sounds heard in the various parts of the vesicular system were produced by vibrations of the walls of the vessels.

Dr. THEODORE WILLIAMS congratulated Dr. Lee on his lucid account of aneurysm as regarded the dyspnœa in thoracic aneurysm. There were two kinds, paroxysmal, and steadily increasing difficulty of breathing; the former he believed to be due to implication of the recurrent laryngeal nerve, and the other to pressure upon the trachea or bronchial tubes. If Dr. Lee's statement that the absence of murmur signified absence of a calcareous deposit were true, it was a most valuable diagnostic sign, but he very much doubted the connection.

Dr. LEARED strongly questioned the statement that all the sounds referred to, were produced only by solids.

Dr. DOUGLAS POWELL thought Dr. Lee's dissection exceedingly interesting. In his opinion the dyspnœa was due to both causes, implication of the nerves and pressure on the air-passages; when it was due to the nerve it was from paralysis and not spasm; the only lesion to the vocal cords was paralysis, as shown by the autopsy. He did not think Dr. Lee's arguments as regarded the production of sounds were conclusive.

Dr. R. J. LEE, replying, said the question of sounds was altogether

most difficult and far more complex than was generally believed. All sound depended on vibration, a point which must be kept in mind. Whenever he found a bruit, there had been a deposit, and where there was no bruit there was no deposit.

March 8th, 1873.

The CENTENARY DINNER of the Society was held at Willis's Rooms, King Street, St. James's; THOMAS BRYANT, Esq., F.R.C.S., President, in the chair. Upwards of 80 Fellows and their friends were present. In addition to the customary and loyal toasts, the success of the Society was proposed by the President, who briefly and favorably reviewed the past and present of the Society, and shadowed forth a hopeful and useful future for its activity.

Silver medals were presented to Dr. Day Goss, the retiring librarian; and to Mr. Royes Bell, the outgoing secretary.

March 10th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. HENRY SMITH brought forward a patient on whom he had performed

RESECTION OF THE ELBOW-JOINT.

Considerable doubt had arisen in the author's mind as to the propriety of surgical interference in this case, as the patient was suffering from chest mischief; but, having had a good result previously in a similar instance, he determined to proceed, and operated in the usual way. The immediate effect was a great aggravation of the chest symptoms; these, however, subsided, and the patient became convalescent. The joint, as exhibited, was a useful one, the man being able to place the palm of his hand on the top of his head, to take off his hat and replace it with perfect ease.

Mr. BRYANT remarked that this case suggested the important

question of operating when organic disease of the lung existed; the old practice was, never to do so. He believed that local suppurative discharge tended to keep up the organic mischief, and might lead by itself to tubercular disease. In his opinion the right practice was to arrest the local suppuration by operation, and his experience was that the thoracic symptoms then abated.

Drs. THOROWGOOD, CHOLMLEY, and SYMES THOMPSON concurred in this opinion.

The PRESIDENT then delivered his

OPENING ADDRESS,

of which the following is a brief abstract:

Ushering the Society into its second century, he felt deeply sensible of the honorable post to which he had been elected, but he feared it would be an arduous duty to maintain the high standing to which the Society had been raised by the untiring efforts, energy, and talents of his predecessors. He congratulated the Fellows on the possession of their present premises, unfinished, it was true, but they were such as gave good promise of being equal to all the requirements of the institution. Since the Society was founded, one hundred years ago, there had been a gradual development of the science of medicine, and it was difficult *now* to realise the position of our profession *then*. Harvey, Malpighi, and Boerhave had lived and worked, and the leaven of their writings had begun to prepare the profession for the great improvements that were to take place. He then called attention to the rapid strides made in medical knowledge during the last century, pointing out some of the most remarkable examples. "What," said he, "would be our knowledge of phthisis without the stethoscope, and before Laennec? What confusion in the treatment of thoracic disease? How different our knowledge of pneumonia and its treatment before disease was regarded in its general aspect, and not as an entity apart from the patient. What was our knowledge of heart disease before the stethoscope and before such men as Hope, Latham, Stokes, Graves, Watson, and a host of others lived? How have hygienic measures prevailed? Simply because vague hypotheses have given place to truth, which has an influence throughout the land. If the work be done well by those to whom the health of greater or smaller districts is committed, if they are thoroughly able to do their work and free to tell the truth, the benefit will be very great. What, again, was known about renal

disease before the time of Bright, and how little it was understood. Surgery was practised for many long years without the use of anæsthetics. If chloroform had not been introduced, ovariectomy and other valuable operations would scarcely have been dreamed of." The President then referred to the introduction of the microscope and the thermometer into clinical medicine, together with the laryngoscope, the ophthalmoscope, and the sphygmograph. He impressed on the Fellows that while they accurately inquired of nature, they neither misrepresented nor went beyond facts, for false statistics and inaccurate observations and deductions had always been immense barriers to the progress of medical science. The Medical Society regards the unity of the maladies of mankind, man in his completeness, the effect of the mind upon the organism, and thus it seeks to avoid the error of specialism. How many mistakes arise from our regarding individual symptoms rather than studying the whole nature of the malady. Reference was then made to the state of the colon in disease of the kidney or acute suppuration in the loins. He then concluded by saying that—"The Society invited communications upon every branch of medical science, on mental diseases as well as obstetrical; and pathological facts as well as clinical experiences were always welcome; and he hoped that, having the help of those present, the year just entered on would prove one of progress to the Society."

Dr. TILBURY FOX then read a paper

ON ACNE.

The author, after referring to the enlarged views which pathology has given us of cutaneous diseases, proceeded to describe acne, when fully developed, as an inflammatory condition of the sebaceous glands; their follicles and peri-follicular tissues, resulting, as a rule, from the irritation produced by the plugging up of the duct by inspissated secretion (which may have undergone some chemical change, and thereby acquired acrid qualities); the degree and character of the inflammation being influenced by a variety of causes that increase the hyperæmia of the face on the one hand, and lead to hyperplastic growths on the other. The main determining occasion of the acne being, physiological action of the glands, about the time of puberty, when the hair is forming about the face, and the face is becoming developed in all its parts, as the boy or girl is changing into the man or the woman. The hyperæmia of the fat glands

is increased by agencies acting directly as stimuli upon the seat of acne, as (1) in the case of external irritants; (2) by agencies that interfere with the gland circulation at the time of puberty, when this should be active, such an uncleanness and all things that produce general debility; (3) by influences which act physically in blocking up the orifices of the sebaceous glands, such as the collection of dust and dirt at the gland apertures in the skin, derived from the rooms in which certain dirty and dusty occupations are followed; (4) by an altered blood state, as when the blood is charged with retained effete products; (5) by general plethora, to use an old expression; and most important of all, by the irritation excited through the reflex function in consequence of the existence of dyspepsia and uterine troubles. The extent of the inflammation depends upon the degree to which the above-named aggravants of the hyperæmia operate, and the *character* of the inflammation upon the constitutional state of the individual. The inflammation will be severe if the patient is gouty, and there will be more or less implication of the cellular tissue about the gland, and free pus formation in proportion as the patient is strumous. In the treatment of acne it is necessary to take all these matters into account; their concomitant conditions concur in a variety of combination, but Dr. Tilbury Fox specified four common kinds of cases of acne.

1. The one in which acne was hereditary, in which the patients were pallid, lymphatic and debilitated, perhaps strumous, and required general tonics, iron, and cod-liver oil, with fresh air, proper exercise, and the local use of some slight stimulant, such as weak sulphur ointment.

2. The "dyspeptic" cases, accompanied, at first, by flushing after every meal, and then by more decided dyspeptic symptoms, and in patients who were generally debilitated, and who required antacids, bitters, and prussic acid, with careful regulation of diet from time to time, previous to their being treated *internally* with arsenic and iron, and *locally* with astringents, such as calamine and bichloride of mercury lotion, after the use in the early stages of soothing remedies locally.

3. The "plethoric" case, where the face was full of blood, the system "loaded," and the patient often constipated, which needed aperients and tonics combined conjointly for some time prior to arsenic treatment, and locally soothing remedies.

And, lastly, the acne rosacea cases, in which the general conges-

tion of the face was intermixed with acne spots. These latter cases occurred mostly in middle-aged women, as a rule, who were subjects of nervous debility, internal disorder, and chronic dyspepsia, and who were often depressed by mental worry, all of which conditions needed special attention before the acne was attacked; the best local treatment consisted in the use of acid nitrate of mercury to each separate acne spot, a soothing lotion being applied to the face; and as regards local treatment, the author insisted on the necessity of avoiding all irritative or stimulative remedies to acne cases in their early stages, and the advisability of employing purely soothing remedies, so long as the hyperæmia remained active.

The paper was followed by a very vigorous discussion, Professor ERASMUS WILSON and others taking part in the same.

March 17th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. GANT showed a case of

RECOVERY FROM VERY SEVERE LACERATION OF THE HAND.

The patient, T. S—, æt. 23, employed on the Metropolitan Railway as a shunter, while coupling waggons had his left hand jammed between the hooks, and extensive laceration of the soft parts of the palm and back of the hand took place. The carpal bones and the bases and shafts of the metacarpal bones were laid bare; there were also compound comminuted fractures of the first, third, and fourth metacarpal bones; there was also considerable hæmorrhage. With such mischief there was, of course, the chance of gangrene supervening, but Mr. Gant, considering how much better wounds of the upper extremity healed than those of the lower, and the patient having youth on his side, determined to make an attempt to save the hand. Tepid water dressings were used for two days, and as there was plenty of warmth in the fingers and the digital arteries could be felt beating strongly, he began the “repressant” treatment, and cold water irrigation was employed for seven days; this afterwards

changed for irrigation with a weak solution of carbolic acid. At the end of three weeks simple water dressing was used, and the wounds all healed. The patient, who was then shown, had considerable power in flexing the fingers, but had little use of the thumb.

Mr. THOMAS BRYANT related a case of

TRACHEOTOMY,

which suggested the expediency of an early operation in cases of continued progressive ulceration of the larynx; as a rule, these cases were left till danger from apnœa was imminent, and the result was permanent occlusion of the larynx as a vocal organ; whereas if the operation were performed early and the parts thus put at rest, the larynx was preserved both as a vocal and respiratory organ. N. A—, æt. 24, admitted into Guy's Hospital, Nov. 19, 1872, with impending suffocation from laryngeal disease demanding tracheotomy, which the house-surgeon, Mr. Turner, performed. She had been married three years, but had not had either family or miscarriage. She had suffered from syphilitic eruption with sore throat for two years, and had lost her voice. The operation was followed by speedy relief and a rapid convalescence. The ulceration of the soft palate healed quickly, and on the fourteenth day Mr. Bryant removed the canula, when he found that respiration went on naturally, although the voice was feeble and husky. Twelve hours after the removal of the canula the wound in the throat closed, and she left the hospital the week following. After the fifth day she took Pot. Iod. gr. x, with Mist. Quin., *ter die*. She was seen two months ago, and described herself as being quite well, and it was noticed that her voice was much improved. Mr. Bryant remarked that medicinal treatment in these cases was rarely of any value without the operation, and when the larynx is the seat of progressive ulceration, these cases go on steadily to the bad.

A discussion ensued on this case, in which Mr. Gant, Dr. Rogers, Dr. Silver, Mr. Spencer Watson, Dr. Sansom, Dr. Tuke, and Professor Wilson, took part.

Dr. THOMAS S. DOWSE then brought forward a patient suffering from

GLOSSO-PHARYNGEAL PARALYSIS.

At the age of 16 he fell from a tree, and the inference was that he fractured the base of the skull; four years after he suffered from a

sunstroke in Canada; he recovered, and seemed to have general good health until about eighteen months since, when he was one day brought home in a fit, and was insensible for an hour. When consciousness returned his wife said that he stuttered, and he had some difficulty in speaking for several weeks. On the 6th of last January he had another fit, followed by paralysis of the left arm and spasm of the muscles of mastication, so that the lower jaw could not be depressed more than half an inch. Attempts were made to introduce the stomach-pump tube through the mouth, but the man was so violent in resisting these that nasal feeding was resorted to. On examining the head a deep furrow of depressed bone was found in the direction of the left parieto-lambdoidal suture. The man had a somewhat idiotic expression of face; the facial muscle most wanting power was the orbicularis oris, this condition permitting the constant dribbling of saliva. The method he adopted for taking solid food was very curious. He crammed the mouth until it could hold no more, and after the food had become moistened and softened by the saliva he pushed it with his finger through the isthmus of the fauces over the epiglottis, where it fell into the grasp of the inferior constrictor of the pharynx, whence it was propelled onward by the action of this muscle. From this Dr. Dowse did not think that the inferior constrictor was paralysed. The man was dumb, the only sound emanating from the larynx was a grunt, and although the thoracic organs were healthy, the loss of power in those muscles made it impossible for the patient to take a deep inspiration. Dr. Dowse, in conclusion, pointed out that there were two important points open for discussion in this case:—1. The nerves involved in this lesion. 2. The nature of the lesion itself. The patient was then brought in, and showed the Fellows the manner in which he fed himself.

A very interesting discussion followed, and, on the motion of Dr. HARRINGTON TUKE, the appointment of a Committee was referred to the Council of the Society.

March 24th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. DAVY exhibited a modified form of Holt's Dilator.

Dr. SANSOM brought forward a specimen of Pulmonary Valvular Disease. He also showed the heart of a man who had died suddenly; the right auricle and ventricle were very thin, the aortic orifice was large and triangular, and the aortic valve was fenestrated.

Mr. HOGG exhibited a set of Eye and other Surgical Instruments. He briefly stated that the instruments were formerly the property of a native doctor of the N.W. Provinces of Bengal, who enjoyed a reputation as a skilled eye-doctor. They were sent to Mr. Hogg by Dr. Calthrop, of H.M. Indian army, who saw the native use them on several occasions.

The Indian operation for the removal of cataract is what would be called in England a rude form of depression or displacement of the lens. The operator takes up his position behind the patient, and proceeds to hang a blunt *upper hook* on to the lower eyelid, for the purpose of accustoming the eye to the feel of an instrument, more than that of depressing the lid. The upper lid is then raised with the fingers of the left hand, and an incision made with a *lancet-bladed instrument*, about the eighth of an inch behind the margin of the cornea. The blade being held perpendicularly to the surface of the cornea, a bold thrust is then made into the sclerotic coat, and immediately on the withdrawal of the lancet a large triangular-shaped upper probe is introduced, and by a dexterous sweeping movement the lens is rapidly displaced. The result of this kind of operation, as might be expected, is very unsatisfactory; in a large number of the cases the eyes are lost by suppuration; and in by far the greater proportion the lens rises again into the anterior chamber, and the sight is lost in a few days or weeks. At first, however, the result appears brilliant, for the patient can immediately count fingers and recognise faces.

The other instruments exhibited were, if possible, still more rude in character, and were employed in lithotomy. With a rough, razor-looking blade, a cut is made into the median line large enough to admit of the extraction of a stone by a roughly-fashioned *iron hook*,

Mr. Hogg also showed some

BUTTONS OF FUSED NITRATE OF POTASH,

which the native doctors use for curing corneal opacities. The button is directly applied to the surface of the cornea, during short intervals daily, and it is said many cures are made with these buttons, the composition of which is supposed to be a secret.

Dr. ALFRED CARPENTER, of Croydon, then read a paper on

SOME CASES OF MALIGNANT PUSTULE

which he had met with in his private practice. After detailing the literature of the disease the author narrated his own experience, which was limited to five cases, four of which had terminated fatally in five or six days; the fifth was now under observation, and he gave the following details of the case:—The patient, a lady, was seized on the 4th of last February, the disease commencing as an itching in the lower lip, with inflammation, hardness, swelling, redness, and tenderness, but without the acute pain which usually accompanies facial carbuncle. It ran a rapid course, and on the 12th and 13th the face, neck, left clavicle, and sternum were much swollen and livid; the power of speech and swallowing was lost. She was kept alive by enemata of beef tea, eggs, and brandy. On the 14th, however, the swelling decreased, and she recovered the power of swallowing. A slight improvement continued, and on March 4th she was able to sit up, and next day she walked from the bed to the sofa. After walking there was evidence of a plug in the vein about the left ankle, which caused much pain, but it disappeared about the 10th. On the 12th there was a relapse, with symptoms of liver obstruction, and she had continued up to that day, suffering more or less. This morning, the 24th, she had a slight convulsive seizure, which lasted twenty minutes, but without loss of consciousness; this was followed by acute pain in the abdomen, and she seemed to be sinking. She rallied, however, and the last report found her feeling much better. The author then drew attention to the points of interest in the case, and detailed his plan of treatment.

Drs. Farquharson, Sansom, and Wynn Williams related cases that came under their own observation. Dr. Thorowgood and Mr. Myers had both met with cases that terminated fatally.

Dr. CARPENTER replied to the questions, and the meeting adjourned.

March 31st, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. MAUNDER showed the

ENDS OF THE BONES FORMING THE ELBOW-JOINT,
REMOVED PRIMARILY FROM A FEMALE, ÆT. 51.

The back of the elbow had been caught in a jute-carding machine, and the teeth had carried away a large tract of skin and lacerated the neighbouring muscles, but the ulnar nerve had escaped. Mr. Maunder excised the joint, with two inches of the lower end of the humerus to correspond with the loss of integument. This patient progressed uninterruptedly well. He also brought forward the

UPPER END OF A HUMERUS REMOVED FROM A
FEMALE, ÆT. 35.

Six years ago she received a blow on the shoulder, and for two years there had been discharge from one or more sinuses and the head of the bone was reduced to one fourth of its natural size. The point of practical interest was, would it have been sufficient to have removed simply the remnant of the head of the bone instead of cutting it through at the surgical neck? He was of opinion that had he left the tuberosity, ankylosis and a stiff joint would have resulted instead of one which bids fair to be useful.

Mr. BRYANT showed a

SPECIMEN OF TOTAL OCCLUSION OF THE RECTUM.

The history of the case, including the operation of colotomy and its progress up to Jan. 30th, 1872, are given in the 'Medical Times and Gazette' for March 16th, 1872. The following is a brief abstract:—Miss B—, æt. 18, had been subject to insuperable constipation for seven weeks. All medicine and food were rejected, and for some time the vomit had been of a yellow colour. The use of rue and turpentine enemata having failed, the ascending colon was opened and the edges were stitched to the external wound, on September 6th, 1871. Motions were passed regularly through the artificial

anus, and the note taken on the 30th Jan. in the following year says:—"At the present time the girl is going about in good health. She has still some straining in the pelvis, and the tumour formed in it is being forced downwards. The patient died of peritonitis on the 21st June, 1872." The post-mortem showed stricture of the rectum of a cancerous nature, and tubercles of malignant matter were deposited upon the neighbouring organs; the bowel was impermeable, not allowing even the passage of a bristle.

The PRESIDENT spoke of a

CASE IN WHICH COLOTOMY WAS PERFORMED,

and in which the patient, who had been suffering from disease of the rectum of a syphilitic character appeared to be doing well. The operation demonstrated the advantage of removing the source of irritation to the bowel by preventing the passage of fæces over it.

An important discussion followed, in which Mr. Allingham, Mr. Maunder, Dr. Wiltshire, and Mr. Davy took part.

Dr. FARQUHARSON then read a paper on an

EPIDEMIC OF ROSEOLA OR SPURIOUS MEASLES.

It was characterised by the appearance of small irregular rosy spots on the chest, spreading from thence to the face and limbs, and fading away by the third day without having shown any tendency to coalescence; the period of incubation was about eight days; there were few premonitory symptoms, the temperature rarely exceeding 99.2° , neither was there hardly any departure from the feeling of general good health; but in some few cases, increased fever and other symptoms seemed to bridge over the distinction from true measles, and in two instances severe and undoubted attacks of well-developed disease proceeded from the contagion of the spurious variety. From this the author was led to infer that this form of highly contagious roseola or rubilla was an abortive or alien type of measles, diverted from its usual course by some epidemic or other mysterious influence.

April 7th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. GANT related three cases of

DOUBLE AMPUTATION,

the notes of which had been taken by Dr. MacKellar, house-surgeon to the Royal Free Hospital. W. S—, æt. 15, was run over by a locomotive on April 20th, 1872, and sustained extensive compound comminuted fractures of the right arm and left leg. The flap operation was performed on both limbs, and with the exception of severe hæmorrhage which occurred during the following night and which was arrested by ligatures, torsion, and pressure, the boy did well, and left the hospital on the 10th June. The lad had been supplied with artificial limbs and walked up to the President's table without the aid of a stick. He was at the present time employed in the office of the railway and able to do the ordinary work.

The second case was that of a boy whose legs had been crushed by the wheels of a passing train on the 9th of August. Amputation at the middle third of the right thigh and supra-condyloid amputation of the left were performed; in the latter case the patella was left in the flap, and during convalescence a small portion of the right femur necrosed and came away. The boy was discharged well after a residence of ten weeks. Mr. Gant showed this little fellow, who looked well and hearty, and shuffled along the floor in a sitting position in much the same manner as children do before they learn to walk.

The third case was that of O. L—, æt. 10. On the 27th of last February he was run over by a tramway omnibus, and the whole of the right leg was so much crushed that Mr. Gant was obliged to perform supra-condyloid amputation after Gretti's method. The left foot was severely crushed and it was feared that rupture of the anterior tibial had taken place. An attempt was made to save the limb, but sloughing took place, and an operation similar to that in the last case was performed, but the child died. In bringing forward

these cases the author remarked on two practical points of interest: 1st. That it was better to amputate an inch or two above the bruised skin, as blood was extravasated higher up in the deeper parts than in the subcutaneous tissues. 2nd. In amputation of the arm it was of great importance to leave the deltoid muscle intact, for then the stump could be moved by that muscle as well as by the pectoralis and latissimus dorsi. Mr. Gant also thought there was less risk of osteo-myelitis when the amputation was performed through the condyles than when the section was made through the shaft of the bone.

Mr. HENRY SMITH showed a case of

TRANSPLANTATION OF THE SKIN.

The patient, a woman, aged about 30, had sustained in October last a very severe burn of the arm and forearm. When she came under his charge the arm was useless, the elbow being bent at an acute angle and kept there by a firm thick cicatrix; this he cut through and then bodily dissected it back in its whole length. He then took a piece of skin two and a quarter inches wide and twelve inches long from the patient's side, and twisting the nutrient pedicle of skin to allow of its being placed on the arm, it was stitched in this position and the arm bandaged to the side. In three weeks the principal part had united. The arm now bid fair to be a useful one, as there was no fear of contraction, the patient being able to extend it fully.

Mr. ERASMUS WILSON said he was much pleased at such a result, and thought skin-grafting would have given good results. He would suggest that the granulations seen in these cases should be covered with some non-irritating ointment.

Mr. BRYANT said it was not necessary to cut through the entire thickness of skin, but it was necessary to include the basement membrane; if the epithelium only was taken the operation failed.

Mr. GANT's plan was to dissect off a piece of skin just deep enough for the cut surface to present an areolar appearance, and having placed this on the granulating surface he covered it with lint and left it for three days undisturbed; on removing the lint an opaque spot would be seen, and a careful examination would disclose a number of small vessels supplying it; and he pointed out the rapidity with which these spots coalesced when their edges approached each other.

Mr. ROYES BELL was of opinion that some length of time should be allowed to elapse before determining the relative value between skin-grafting and transplantation; and

Mr. ADAMS pointed out that different modes of treatment might be adopted in the same case at different parts. He mentioned the treatment he had described to this Society some years ago. It consisted in punching a hole through the cicatrix and then gradually dilating it.

Dr. FAYREB, C.S.I., then read a paper on

EUROPEAN CHILD-LIFE IN BENGAL.

The author pointed out how rapidly the infant European population was increasing in India, and contrasted the mode of life in that country twenty-five years back with what it is now. The death-rate per 1000 among the troops was 17·83, and among the officers 12·49. The question had been often asked, Can the Anglo-Saxon colonise India? *i.e.* can the race unsupported and unrecruited from home continue to reproduce itself and exist there? Could he, in short, do in India what he has done in America and Australia—people the country and displace or replace the antiocthones and his older Arian brethren who have become acclimatised during an occupation of many centuries? Dr. Fayrer was of opinion that the data for framing a precise reply to this question did not exist, but his own firm conviction was that it could not be done, and he felt convinced that had India been colonizable by the European, the position we now held there would be very different to what it is. The European who becomes an item in the fixed population, and who leads an ordinary temperate and correct life, has expectations of living perhaps little below those he might have had in England. About the year 1815 an asylum was founded in Calcutta for children whose parents were Europeans, and it is from the reports of this Society, numbering about 129 individuals, varying in age from one to eighteen years, that the following information is gathered. It was observed that the stimulating effects of an almost tropical climate asserted their influence, and, as a rule, a girl of sixteen or seventeen years was two or three years in advance of a girl of that age in an European climate. As regards the age at which the catamenia appeared, and which, having appeared, generally were regular and without trouble, the earliest age was twelve years and two months, the latest sixteen years and four months. In connection, though

perhaps remotely, with this subject, Dr. Fayrer noted the rare occurrence among the girls (two or three cases of bucnemia only happening in twelve years) of a swelling of the lower extremities evidently nearly allied to the elephantoid growth seen in the limbs of the natives of Bengal. It is manifestly a steady enlargement of one leg mostly about the ankle and leg, but extending sometimes to the thigh; if there be any change in the condition, it occurs at the menstrual period, when the limb is sometimes larger than at other times. The swelling is firm, not œdematous, and very like elephantiasis, except that it is not attended with either pain or excitement in the part, but is a very slow steady growth. One of the finest girls in the school is affected by it, medicine does not seem to affect it, and bandaging only produces temporary improvement. These children appear to have a great immunity from diseases peculiar to the country as well as others of a severe kind; thus, no cases of cholera, diphtheria, scarlatina, croup, pleurisy, pneumonia, ophthalmia, phthisis, dengue, or malarious cachexia have been known among them; for many years previous to the author's observation. The death-rate is about double that in England, as the following table will show:—

	Years.	England.	India.	
Under	5	67·58	148·10	per 1000.
From	5 to 10	8·80	17·73	„
„	10 to 15	4·98	11·51	„

The author quotes Miss Nightingale's true saying, "Children are, as it is well known, the very touchstone, the live tests of sanitary conditions, and but too often the dying and dead tests of insanitary." The author concluded by saying that it was satisfactory to know that by care and proper training an European child may live, grow, and even thrive in the plains of Bengal.

Professor ERASMUS WILSON, Dr. TILT, and Mr. JABEZ HOGG made some remarks, and, thanking Dr. Fayrer for his paper, the meeting adjourned.

April 21st, 1873.

S. O. HABERSHON, M.D., President, in the chair.

Dr. BOYD read a paper on

STILLBORN AND NEWLY BORN INFANTS.

He pointed out that intra-uterine disease was not an uncommon cause of abortion, and that weakly children may be born of apparently healthy mothers. Also, that from the great difference found of the relative weight of the lungs to the body, there were insuperable objections to Ploucquet's test. He referred to the case of an infant some days old, whose weight was considerably under 3 lb. The preponderance of males in stillborn children was remarkable, for out of 131 cases, 79 were males and only 52 females; on the other hand, in 90 new-born infants, the numbers were equal. The average weight of the body in stillborn children at the full period was, in males, 6 lb. 9 $\frac{1}{4}$ oz.; in females, 6 lb. 2 $\frac{1}{2}$ oz. The average weight of the new-born male, 5 lb. 1 oz., the female, 4 lb. 3 $\frac{3}{4}$ oz., was very much less than the average weight of stillborn children at the full period, the difference being 1 $\frac{1}{2}$ lb. in males and 2 lb. in females. The difference in the average weight of the body and organs in the two sexes, even at this early period, was well marked. It was worthy of notice that, in 131 cases of married women, the average weight of the children was 7 lb. 1 oz., while the children of 209 single women weighed only 6 lb. 10 oz. The average length of a stillborn child at the full period is 19 inches, in those who have breathed it is 21 inches.

Dr. WILTSHIRE greatly regretted that the compulsory registration of stillborn children was not carried out in this country as it is in Prussia, and he mentioned several instances in which this neglect had given rise to gross malpractices. The difficulty of legislating on the subject arose from the uncertainty of the age of the fœtus; in his opinion the length of the child was the best test, but this could not always be depended upon, as it varied nearly as much as the weight.

Dr. SCHUMACHER, of Aix-la-Chapelle, introduced by Dr. E. Symes Thompson, related a case of

ANEURYSM CURED BY GALVANISM.

The patient, a young man, æt. 30, had been the subject of femoral aneurysm for one year. The sac, about the size of a double fist, was situated just below Poupart's ligament. Instrumental and digital compression having failed, chloroform was given and a tourniquet applied to the external iliac artery, arresting the circulation entirely. The needles connected with the poles of a thirty-cell battery were passed into the sac and kept there for twenty minutes, the direction of the current being alternated every few minutes. The tumour became as hard as wood, and on the tourniquet being removed no pulsation was detected in it; the instrument, however, was re-applied and the circulation arrested for two hours, the patient remaining under chloroform. During the next forty-eight hours there was some sanious discharge which came from the tissues external to the sac, and seemed to have been produced by the irritation of the needles. The patient is at present walking about quite well, and one limb is as well nourished as the other; but on the side operated on no pulsation is to be detected in any of the blood-vessels, not even in the dorsalis pedis and in the posterior tibial. Dr. Schumacher said that this treatment had been successful in cystic tumours of the thyroid.

Dr. LEONARD SEDGWICK then communicated a paper from Dr. R. Schmitz, of Neuenahr. In commencing, a short account of the waters was given, and the constituent parts were shown to be :

Carbonate of soda	.	.	gr. 10	} in 16 oz.
„	magnesia	.	gr. 3	
„	lime	.	gr. 1	
Oxide of iron	.	.	gr. $\frac{1}{10}$	

Four cases of diabetes were related which had been treated by Dr. Schmitz with strict diet and large quantities of the “grosse sprudel” water of Neuenahr, and in each case a perfect and lasting cure was effected. During the last four seasons he had treated 43 cases of diabetes mellitus; of these there were 12 cures, in 21 the saccharine matter was materially lessened, and in some it was reduced to a minimum. The subjective appearances were considerably dimi-

nished, and in several instances so entirely removed, that a continuance of the treatment would have ended, to the best of the author's belief, in perfect cure. In 10 patients nothing satisfactory was obtained from the use of the waters, but of these, 3 came in a dying state, 2 discontinued the treatment after scarcely eight days, and in the remaining 5 the disease had either entered its last stage or was complicated with Bright's disease, disease of the heart, amyloid disease of the liver and kidneys, advanced phthisis, or it was the sequel of incurable disease of the cerebral nervous system. The fifth case was one of acute diabetes coming on with febrile symptoms; it was also notably hereditary. Dr. Schmitz had remarked that all his cases were suffering more or less from gastro-intestinal disturbance, and that eight of them said that the diabetes immediately followed on what they called an attack of gastric fever. The author was of opinion that the original seat of diabetes is to be looked for in the small intestine, where, in consequence of a fault in the digestive processes, the sugar of the food is not chemically changed as in health and so is absorbed as such. It is, therefore, as a remedy for this defect that alkaline waters by their direct influence on the tractus intestinales are of great service; and he thought that the pancreatic juice exerted a large influence on the sugar of the food in the duodenum, and remarked that in cases of death from diabetes the pancreas had been found much atrophied.

Dr. FARQUHARSON thought that the foreign spas produced their good results chiefly by means of the change of air, scene, good diet, and regular living, and that generally the improvement was scarcely due to any special peculiarity of the waters.

Dr. HAINWORTH drew attention to the difficulties in the treatment of this disease in the less educated classes of society.

Dr. WILTSHIRE mentioned that in carrying out the skim-milk treatment Dr. Donkin had always found an increase in the quantity of sugar when the patient partook of new milk.

Mr. BRUDENELL CARTER said he had a patient who had been under his care for ten years, and who during that time, when suffering from any mental worry, although his general health was good, always found an immediate increase of sugar.

Dr. SEDGWICK, in reply to a question, said that he believed the carbonate of iron and lime in the water acted as sedatives, improved the digestion, and thus tended to better the patient's condition.

April 28th, 1873.

S. O. HABERSHON, M.D., President, in the chair.

Mr. J. S. STREETER mentioned a case of

**TWINS HAVING ONLY ONE CHORION, ONE CHILD
BEING DOUBLE THE WEIGHT OF THE OTHER.**

Both were alive when born. The smaller one drew in air and fully inflated the chest, but the larger and more powerful child did not breathe at all. He also showed drawings of various abnormalities existing in stillborn infants where the heads were enlarged, and the necks much elongated; and many pictures showing the umbilical cord twisted around the neck in various ways.

Mr. SPENCER WATSON showed a patient, *æt.* 50, in whose vitreous humour an ophthalmoscopic examination detected a long dark filament of lymph floating freely about.

Dr. SANSOM communicated the following case of

CONGENITAL HYDROCEPHALUS.

Kate T—, *æt.* 11 weeks, came under his care as out-patient at the North Eastern Hospital for Children, April 9th, 1872. The father died of phthisis. The child was well developed but never took any notice, and the head was persistently retrojected, the fontanelles were distended and fluctuant, and the parietal bones became gradually separated. There was no vision, progressive languor occurred, and the child died on the 20th April. The post-mortem showed all the organs healthy except the encephalon. The brain was pale, and puncture at the base caused a gush of half a pint of serous fluid with flocculi of lymph floating in it. The cerebellum was distended with this fluid, as well as the lateral ventricles, the brain substance forming a thin investment of the fluid.

Dr. CROMBIE showed a heart, the pericardial surface of which was covered with fibrinous flocculent deposits of lymph, much resembling granulations, apparently the result of repeated attacks of pericarditis. It was taken from a woman, *æt.* 45, who had never suffered from rheumatism, and in whom pericardial friction sounds were not

detected. The pericardial cavity was distended with fluid at the time of death.

Dr. WILTSHIRE suggested the use of the aspirator in cases like this for the removal of the fluid, the pericardium having been punctured several times with marked benefit.

Dr. SANSOM said, should he have occasion to tap a hydrocephalic head he should certainly employ this instrument, which Dr. Broadbent had employed on several previous occasions with benefit.

Mr. JOHN HAINWORTH said that the idea of tapping the pericardium was not new, for as early as 1826 he recollected a case in which this operation had been performed by an English surgeon.

Mr. SPENCER WATSON read a short paper on the

SUBJECTIVE SYMPTOMS OF EYE DISEASE.

He showed how some forms of *muscæ* were merely physiological and seen only under certain peculiar circumstances. Spectral images were sometimes caused by floating films on the vitreous, and when the patient so affected was fanciful or superstitious, definite forms were described as appearing before him, though as a rule no uneasiness of this kind was occasioned beyond the anxiety incidental to the prospect of rapid failure of sight. Coloured spectra and double images were described, and various theories for their appearance given, and the formation of multiple images in a single eye was demonstrated by means of lenses. Various instances of remarkable subjective symptoms of disease were related, and a case of cataract in a myopic patient was related, in whom the physical signs indicated a mature cataract, while the vision remained perfectly good for near objects; this was not unfrequent with myopia, and the author drew attention that the subjective symptoms in such cases were very important as a means of correcting the conclusion drawn from ophthalmoscopic investigations.

Dr. E. SYMES THOMPSON then brought forward two cases of

PERITYPHLITIS, IN WHICH RECOVERY TOOK PLACE.

The first was seen in consultation with Mr. H. Hemsted, of Whitechurch, who furnished the following notes:—T. H—, æt. 20, farmer, had an attack of colic followed on the third day by severe pain and tenderness, which gradually lessened under leeches, calomel and opium. At the end of a fortnight, pain in the back was complained of, and some fulness was detected in the right loin; the symptoms be-

coming urgent, pulse fast, temperature high, with frequent vomiting, a grooved needle was introduced to the depth of two inches midway between the last rib and crest of the ilium, a dark foetid matter escaped, a trocar and canula were then used, and half a pint of horribly offensive matter escaped, the wound was plugged with oiled lint; twice a day the lint was removed, and for several weeks a pint and a half of matter was discharged daily. Several fragments of vegetable marrow and on two occasions grape stones were discharged, showing that an undoubted communication existed with the bowels, although no pus passed per anum. Eventually the discharge ceased, and the wound healed after having been open for nine weeks.

CASE II.—Seen in consultation with Mr. Marshal, of Mitcham. W. S—, æt. 42, was attacked when in bed with violent griping pain in the abdomen, with vomiting, tenderness, increased on pressure, especially in the right iliac fossa. Here the percussion note was dull, the abdomen being elsewhere tympanitic, there was a decided fulness and hardness, giving the impression of an elongated tumour the size of a hen's egg. The patient had eaten nothing to account for the attack, but about a week before, while eating a piece of bread, some sharp substance, which may have been a pin, scraped his pharynx, leaving a sense of soreness for several days. Calomel and opium were prescribed and linseed poultices applied. The pain in the region of the cæcum continued very severe, opiates and leeches were employed, and there was great prostration of strength with rapid pulse. At the end of a week the abdominal tenderness abated, and the patient gradually rallied, although for many weeks the lumps in the iliac region threatened to suppurate; these eventually dispersed and the patient is now well; a perceptible hardness, however, remains in the region of the cæcum.

Dr. THOMPSON said that it was not always easy to distinguish between colic, intussusception or other obstruction, peritonitis, inflammation in or around the cæcum, but the diagnosis must be made before commencing treatment, for unrelieved fæcal accumulation was a cause of inflammation and so was violent purgation. In Case I, the colic, impaction and inflammation about the cæcum led to the escape of the contents of the bowel into the sub-peritoneal tissues with consequent formation of matter in the most dependent part. In Case II, it seemed impossible to decide whether the peritonitis, with sub-peritoneal thickening threatening abscess, was due to the escape of any foreign body from the bowel. The history of the case favoured

this view, but the subsidence of the swelling without discharge of matter appeared to negative it.

Drs. Habershon, Carr, Routh, and Mr. Victor de Méric spoke in the discussion which followed, and the meeting adjourned.

May 5th, 1873.

THE ANNUAL ORATION AND CONVERSAZIONE.

The ANNUAL ORATION was delivered by Dr. JOHN COCKLE, being a

REVIEW OF SOME RECENT DOCTRINES CONCERNING
THE MIND.

At the conclusion, the PRESIDENT proposed a vote of thanks to the author, with a request that Dr. Cockle would publish his Oration. This was carried with acclamation.

The CONVERSAZIONE followed, which was well attended, upwards of two hundred Fellows and their friends being present.

October 20th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

The PRESIDENT congratulated the Fellows upon the completion of their new premises, and also upon the prosperous condition of the Society; and whilst referring to the numerous additions made to their ranks, he spoke with much feeling of the losses they had sustained by the decease of Mr. Bishop, Mr. Streeter, and Mr. Harrison. He then alluded to the meetings of the British Medical Association and of the British Association, at Bradford, and observed that the Medical Society of London sought to gather up the golden grains of truth which were washed down into the fields of practical life from the higher region of transcendental science, and endea-

voured to apply the facts of physiology and pathology in the elucidation and alleviation of disease. To illustrate this he touched upon the skill displayed by our practical physicians in determining the cause of the late epidemic of enteric fever in the neighbourhood, and concluded by saying that "Our Society seeks for knowledge from every source, and endeavours to apply that knowledge in everyday practice. In societies where transactions are published the usefulness must be enhanced; and although we have been behind-hand in this respect, we hope to be so no longer, but to make known to each of our Fellows the valuable communications read in this room."

Dr. RICHARDSON, F.R.S., then read a paper on

ORGANIC STRICTURE OF THE ŒSOPHAGUS.

This was written purely as a clinical essay for immediate practical use, therefore all pathological theories as to the nature of organic stricture of the œsophagus were omitted, and the author submitted four subjects for consideration in relation to this disease:—*a*. Its development; *b*, its destructive characteristics, including the differential and the absolute diagnosis; *c*, its progress; *d*, its treatment. After defining what he meant by organic stricture, namely, a stricture of organic growth, and excluding from his present purpose the study of temporary or spasmodic and of traumatic stricture, Dr. Richardson detailed ten typical cases of the true organic disease, and observed that he had based his facts and suggestions on the phenomena he had noticed in these cases.

A. Development.—Under this head Dr. Richardson dwelt on its malignant character as shown by the hereditary history of malignant tendency in those who suffered from it; on the absence of syphilis, tubercle, and struma as predisposing causes, on the equalisation of the malady between the sexes; on the periods of life most favorable to its development; on the position of the disease in the œsophageal tube and its insidious progress; on the infrequency of traceable mechanical injury as a direct existing influence, and on the frequency of indirect injuries through mental nervous shocks as existing influences.

Diagnosis.—Under the head of diagnosis, Dr. Richardson first pointed out how often the earliest symptoms were hidden from, or mistaken by, the patient suffering from stricture. How such patients would refer their symptoms to chronic bronchitis, dys-

pepsia, or other affections ; or how, knowing they had a difficulty in swallowing food, they would neglect the fact until exhaustion began to tell upon them ; until, in short, the moral of the old fable of the belly and the members began to be personally realised. The earlier symptoms were carefully detailed and their respective values described. The value of objective, as distinguished from, and superior to, subjective evidence being specially enforced. The differential diagnosis was also entered into in detail as between the organic stricture and constriction from spasm, constriction produced by external pressure on the œsophagus, as by goître, aneurism, mediastinal abscess, or mediastinal tumour ; constriction from reflex irritation and constriction from traumatic lesions. Afterwards the absolute diagnosis was described from the subjective, the objective, and the physical symptoms that specially establish it. Finally, in this division of the paper, the difficulties of diagnosis in cases complicated with laryngeal disease, or with chronic or sub-acute bronchitis, or with affections of the stomach, were pointed out.

Progress.—Under the head of progress of the malady the author dwelt on its fatal character. He had, he said, heard of recoveries, but he had not seen any, although he had sometimes seen a respite of symptoms and temporary partial recovery. The progress towards death varied in different cases, and he had observed several distinct forms of death, viz. by pure starvation, by the effect of surgical accident in endeavouring to dilate the stricture, by suffocation from extension of the disease to the trachea and larynx, by suffocation from an exudation into the bronchial tubes excited either by nervous irritation or by passage of mucous secretion from the œsophagus into the larynx and bronchial cavity ; and, lastly, by coma and convulsion. These various progresses to the fatal termination of the disease were illustrated with minute carefulness from direct personal observation, particular stress being laid on the suddenness with which death comes on in those instances where coma and convulsion are the immediate forerunners of dissolution. This mode of death, Dr. Richardson said, was most common in feeble persons rather advanced in life, and it was equivalent in character to coma induced by cold. It was preceded by a decided fall of animal temperature ; in one example by a fall of nearly 3° below the natural standard. Hence, the author urged, as a special warning, that when in a case of œsophageal stricture the animal temperature begins to fall, though the stage of actual deprivation of food be not

reached, it is right to be on guard for coma, convulsions, and sudden dissolution. The influence of the season on the waste and repair of the body was introduced briefly at this point, and it was shown that in the month of March there was the most decided tendency to rapid bodily waste.

Treatment.—Under the head of treatment the author, after defining that such treatment should be accepted as palliative and alleviating only in our present state of knowledge, insisted on systematic feeding as the first rule of treatment. This would be admitted generally, but the difference was in the supply of food. The common practice was to attempt to dilate the stricture to enable the patient to swallow. This he thought wrong, and considered that the first effort should be made to pass through the stricture a small tube by which food could be introduced, to get the parts accustomed to the tube and to let dilatation follow. The reasons for this plan having been offered, the details of feeding were considered, and foods were classified according as they ought to be administered, by the stomach through the feeding-tube, or by the rectum.

Dr. Richardson showed that only foods of the crystalloidal and water types could be given with advantage by the rectum ; foods of colloidal character (albuminoid foods) were useless when thus given ; the albumen was simply deposited on the mucous membrane, and was decomposed, and occasioned flatulency and disturbance. These foods required to be digested in the stomach before they could be taken into the circulation. Fatty foods required the lacteal system for their absorption, and they also must be administered through the stomach ; by the rectum water can be introduced, and sugar and alcohol with water. Different formulæ were here described for food requiring to be administered by either channel. For introducing food by the mouth through the stricture a double current tube was advisable, as the passage of gases from the stomach was often an obstacle to the passage of food. A tube newly constructed on this principle was exhibited ; there was also exhibited another tube through which the patient might swallow liquid food himself after the tube had been introduced ; and a bottle for the feeding process, which bottle by a change in arrangement could be used for injection of fluids by the rectum. Directions for keeping up the temperature of the patient and for the employment of alcohol were noticed at length.

In some cases, where there is profuse secretion in the œsophagus and accumulation of secretion above the stricture, it is advisable to clear the tubes. To affect this the author showed a tube fitted with a sponge in a sheath; the sponge answered well for absorbing and removing the secretion. Medicines could not, the author thought, be administered in cases of œsophageal stricture for the purpose of effecting a cure, but still medicinal measures were not to be despised; they were often of great value, especially those of a narcotic class; indeed, to secure sleep was not less important than to provide food and warmth. The stomach, however, should never be troubled with medicines; they should be introduced either by subcutaneous injection or by enemata, or by inhalation. For procuring sleep the author preferred the method of inhalation of a volatile fluid; bichloride of methylene and pure methylic alcohol in equal parts formed the best combination for this purpose. The question of dilatation of organic œsophageal stricture in certain cases was now brought under consideration, and objection was taken to all dilators that act as wedges, and which press the strictured part downwards. Mr. Durham's dilators were commended as the best up to the present time. A new dilator, by the author, in which lateral dilatation was secured by air or water pressure, was laid before the Society as an instrument promising to be of great service. It was quite impossible he, the author, believed to tear or rupture the œsophagus with the dilator. On the performance of the operation for gastro-tomy Dr. Richardson spoke with reserve; it could, he thought, never be more than a doubtful and temporary measure so long as we fail to control the progress of the disease in the œsophagus. If we could find means to control the progress of the stricture, then we might have to consider this operation more earnestly. The author would himself prefer to open a communication into the small intestine—if an operation was demanded—through the parietes rather than into the stomach. Dr. Richardson, in conclusion, referred briefly to the experiments he had made for the purpose of being able to feed by the veins, but as his researches on this subject were incomplete, he proposed, with the permission of the Society, to bring them forward at a future time as a distinct communication.

In the discussion which followed,

Dr. SEMPLE narrated several cases in which the cachexia, so usually seen in cases of malignant disease, was absent.

Mr. MASON asked whether Dr. Richardson had tried a method he

himself had adopted, and gave the particulars of a case of traumatic stricture which occurred after swallowing oxalic acid. In this instance marked benefit had followed dilatation with an instrument he had devised, somewhat resembling Holt's dilator for stricture of the urethra.

Mr. DURHAM thought that although most organic strictures were beyond dispute cancerous, yet that some considerable numbers might be set down as fibrous and not malignant. Out of more than 500 cases, the details of which he had collected, upwards of 300 were cancerous, 70 to 80 were doubtful, some probably malignant; in about 100 cases they were of traumatic origin. Those remaining were certainly syphilitic, and some probably had followed simple ulceration of the œsophagus, or ulceration associated with the exanthematous fevers. In one case the stricture had taken place after an attack of scarlet fever, at the age of fifteen. In this case the patient's power of deglutition gradually diminished, and for a period of fifteen years he had lived on fluids only. About the age of thirty he came under Mr. Durham's treatment in a state of impending starvation. Dilatation by means of bougies was commenced, and in between three and four months he was able to take solid food. At the present time, about three years since the commencement of the treatment, he is well nourished, fat, and lives in the ordinary way, eating and drinking like any other person. Two strictures existed; one below the larynx, the other a little above the entrance to the stomach; the upper one at first only admitting a small urethral bougie. Some œsophageal bougies of Mr. Durham's own design were shown, made by Messrs. Krohne and Seseman; these had already been referred to and commended by Dr. Richardson. He pointed out that an internal stem of pewter enabled the instrument to take and retain any curve given to it. The end was a doubly conical bulb, the stem much thinner than the thick part of the bulb, as in some urethral bougies. Thus the operator was enabled to explore the canal with greater ease and much less discomfort to the patient than when the ordinary bougies were used, especially as the epiglottis and larynx were less pressed upon. He was of opinion that, although the operation of gastrotomy might not have prolonged life, yet it had still been beneficial, as it eased the last moments of the unfortunate sufferers in these cases. He had himself operated in one case, and had assisted in two others. He was satisfied that full justice had not yet been done to the operation. He had found that

the terrible thirst in obstruction of the œsophagus relieved in a most striking manner by the immersion of the patient in a bath of milk and water.

The discussion at this point was adjourned until Monday, the 27th inst.

October 27th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Dr. JOSEPH ROGERS showed

A PATIENT WHO HAD LOST THE WHOLE OF HIS PENIS BY SLOUGHING.

He micturated through a small hole in the centre of a large cicatrix, which covered the pubes. The man was admitted into the Westminster Union in a nearly dying state. After promiscuous intercourse while in a state of intoxication, the member had become red and swollen, and, when admitted, two inches of it were gangrenous; the prepuce was divided, and the glans penis was of a dusky red colour; this deepened, and in forty-eight hours the whole was quite black. Stimulants were given with steel and narcotics, and a line of demarcation formed, where the urine escaped. The gangrenous part was then removed with a knife, and the surface touched with nitric acid; cicatrization then gradually took place.

Mr. DURHAM said that he regarded this as a case of syphilitic sloughing, and remarked that in most of these cases he had noticed, as in the present instance, that the patients had been very drunk at the time of connection. He gave particulars of a case in which, after similar sloughing had taken place, the man suffered from incontinence of urine, from the large size of the ulcerated opening through which it passed, and great good had been done by causing the edges to contract by the repeated application of the actual cautery.

Dr. STOCKER said that he had seen opium in large doses exert a most beneficial effect in arresting sloughing.

Dr. J. M. FOTHERGILL suggested that the cause of the sloughing was vaso-motor paralysis of the vessels of the penis.

Mr. CHURTON, of Erith, showed part of the diaphragmatic pleura and pericardium of a child, æt. 1 year 11 months, who had died of suppurative pleuritis, accompanied with pericarditis. He stated that his experience was, that the inflamed serous membranes of patients living in the low districts, near the river, ran on to suppuration very rapidly.

Dr. FOTHERGILL supported this view, stating that along the shores of the Baltic a low form of pericarditis existed, accompanied by the rapid effusion of blood into the pericardial cavity.

Dr. THOROWGOOD considered cases of this kind very rare, vomiting being generally a very common symptom, whereas none took place here.

Dr. WILTSHIRE then read the heads of the paper read by Dr. Richardson on "Organic Stricture of the Œsophagus," and the discussion was continued,

Mr. PETER MARSHALL remarking that he had experienced much difficulty in the differential diagnosis in cases of severe dyspepsia, accompanied with vomiting.

Dr. EDWARDS CRISP believed stricture of the œsophagus was more frequent in males than in females, and that it existed more generally in the upper and lower parts of the tube than in the middle, and it appeared to him to occur amongst patients of intemperate habits. He deprecated gastrotomy, or any other operation calculated to shorten life, though it might alleviate the patient's sufferings.

Dr. HEYWOOD SMITH considered that this operation had fallen into disfavour from its having been resorted to at the latest period. He spoke of the advantage of colotomy in malignant disease of the rectum, and urged that gastrotomy to be of use should be performed much earlier.

Dr. E. SYMES THOMPSON related a case of this disease where ulceration had taken place into the bronchus.

In replying, Dr. RICHARDSON said that some of the speakers considered this disease as more particularly the province of the surgeon than the physician. He was of opinion that the distinction between physicians and surgeons should be done away with, and looked forward to the time when all alike would call themselves "practitioners." In each of the cases he had mentioned there existed a clear history of malignant disease, and all showed some symptom of nervous exhaustion. He thought that a dilator on Mr. Holt's principle might be serviceable, as it produced lateral pressure ; with

respect to gastrotomy he could not recal a single instance where life had been prolonged by the operation. In his opinion, the chief points to be attended to were, the feeding of the patient more by the rectum than is usually done, the injection of food into the stomach through a small catheter, and at the same time the quieting of the nervous system by means of the inhalation of the vapour of a mixture of bichloride of methylene and methylic alcohol.

November 3rd, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

A letter was read by the PRESIDENT from Dr. Rayner, of Highbury, informing the Society that he would give £50 if before the next meeting nineteen other Fellows would do the same, thus forming a fund of £1000.

The thanks of the meeting were warmly accorded to Dr. Rayner for his kind and liberal offer.

Dr. SEMPLE showed a woman suffering from

ANEURYSM OF THE AORTA,

in whom there was some erosion of the ribs, allowing the tumour to be felt beating under the skin. The patient, a sallow-looking woman, æt. 40, had been ill since Christmas last, and had had daily hæmoptysis for a week. There was evident tumefaction of the left side of the chest above the nipple, the ribs on the right side could be seen plainly, especially the second rib, but on the opposite side their position could only be felt. The superficial thoracic veins and the left external jugular were swollen. On palpation there was found to be a decidedly increased impulse over the cardiac region, and beyond it, superiorly and laterally on the left side; the pulse was 108, weak, but regular. On the stethoscope being applied it was lifted up with a heaving motion at each pulsation of the tumour, and there was a distinct blowing murmur heard over it, specially to the inner side of, and a little above, the left nipple. The apex of the heart beat as low as the lower margin of the seventh rib.

Dr. BERKART read a paper on

THE PATHOLOGY OF ASTHMA.

He said Laennec was inclined to think that asthma was due to a disturbance of innervation, and that the disease was not located in the lungs. Subsequently the spasmodic theory developed, chiefly because, from the absence of physical signs, or rather from their insignificance compared with the intensity of the symptoms, it was supposed that the lungs were healthy, and because experimental physiology apparently supported the nervous origin of the disease. Neither of these causes can stand the test of inquiry. With regard to bronchial structure, it is only known that the bronchioles may contract, but nothing as to the how or the when. Paul Bert has shown that they cannot contract if the lung is over-distended, and as this condition, independently of the nutritive disturbance of the pulmonary tissue, constitutes the principal element of emphysema (in connection with which asthma occurs most frequently), it cannot be due to spasmodic contraction of the bronchioles; moreover, in consequence of the catarrh which in the vast majority of instances accompanies or precedes asthma, the bronchial muscles are so thoroughly soaked with serum that they are completely paralysed, and are unable to contract. The author maintained that asthma represented one link in a chain of affections which commenced with diseases of the bronchi and terminated with emphysema, asthma being the latent stage of development of emphysema. He defined asthma to be a symptom which accompanied all pulmonary affections, in which congenital or acquired deficient elasticity of the lungs is the prominent feature, in consequence of which the diminished expiratory forces are only after prolonged and increased effort able to overcome an obstacle to the interchange of gases. The exciting causes of asthma are—(1) very tough and fibrinous mucus firmly adhering to the bronchial wall; (2) catarrh from the inhalations of foreign substances, especially ipecacuanha, pollen, and *asthmaton ciliaris* (Salisbury); (3) displacements of pellets of mucus into a larger bronchus after forced expiratory efforts, such as laughing, &c.; (4) formation of crusts on the mucous membrane of the lung, a process analogous to the one observed on the tongue, and on the nasal and pharyngeal mucous membranes; (5) interstitial oedema, as in gout and Bright's disease; (6) thrombosis, and

embolism of the smaller branches of the pulmonary and bronchial arteries.

Mr. HOOPER said that he had suffered severely from hay asthma this summer, and had tried various remedies, and had found nothing so good as a short residence at the seaside.

Dr. THEODORE WILLIAMS said that the author had boldly attacked old theories, but had not proved a new one to be correct. In his own experience asthma often began without any catarrh, and often only affected certain people in certain districts. He saw this well exemplified when travelling abroad, for he noticed that some of the passengers in the train with him were seized in certain regions through which they passed with sharp attacks of asthma, and then as they left these places the breathing of these people became natural. As well as this, the theory broached would not account either for emotional asthma, or the asthma produced by dyspepsia. Again, if the disease depended on the diminished elasticity of the lung in general, it should exist in the suffocative catarrh of the dyig , but it does not.

Dr. THOROWGOOD concurred with Dr. Theodore Williams. It had been shown that belladonna and stramonium diminish the contractility of the bronchial muscular fibres ; and if the asthma depended on diminished elasticity, he did not understand how these remedies effected the good they did. At the present time, abroad, it was thought this muscular theory as upheld by Dr. Williams was an erroneous one, and some French works on the subject had gone so far as to say that this theory was no longer held by any man in his senses.

In his reply, Dr. BERKART maintained that there was no proof whatever that asthma consisted in a spasmodic stricture of the bronchioles ; on the contrary, that all well-authenticated facts of physiology and pathology render it highly improbable, if not impossible, for such to be the case. He adhered to every statement made in his paper, the more so as every sentence of it could be proved to the satisfaction of every one.

Dr. ROUTH showed a specimen of

RENAL CALCULUS.

Mrs. S— came under his care about twenty-five years ago, at which time she was suffering from piles, with considerable uterine irritation, for which she was treated and cured. About twenty

years ago she went to Australia, where she had a paralytic stroke with loss of power in one arm, and some difficulty in speaking. She recovered from this and returned to England. About sixteen years back she became subject to agonising pain in the region of the kidneys; it came on in paroxysms of a most acute character. This lasted for six or seven hours at a time and then disappeared, and during the attacks she was kept for hours under the influence of chloroform, or the subcutaneous injection of morphia. While in this state there was nothing very remarkable about the urine; once or twice an alkaline reaction was noticed, but nothing more; the water was clear and without pus or blood, and only a trace of albumen. Sp. gr. 1018. The case was seen by Brown-Séquard at the time, who diagnosed it as a case of neuralgia of the kidney, and said that such cases were frequent at the Mauritius. These paroxysms continued for two or three years, and then disappeared. She became very obese, had incontinence of urine, and died at the age of sixty-three of effusion at the base of the brain. At the autopsy the brain was found to be softened, the left kidney was normal in size. There were two cysts on it and imbedded in its substance, and close together were two stones the size of haricot beans. The right kidney was much larger than the left, and contained many cysts full of dark discoloured pus in the calyx; towards the lower end were two large irregular-shaped stones close together, but not adherent. These were lodged in a sacculus, and in the recent state weighed four drachms. Dr. Routh pointed out in this case that there was a remarkable absence of blood, pus, and albumen in the urine, and that the urgent symptoms remained in abeyance many years before death.

Mr. HALPIN also showed a very curiously-shaped

RENAL CALCULUS.

The patient, a girl, *æt.* 15, had suffered from incontinence of urine from birth. About two months before her admission into the hospital she had been attacked with vomiting and diarrhœa, accompanied by great pain in the lumbar region; these became constant and death ensued in four weeks.

Mr. BRUDENELL CARTER said that the ophthalmoscope occasionally showed functional as well as organic kidney mischief. He was consulted by a lady for sudden dimness of vision occurring in one eye. On making an ophthalmoscopic examination, he found there

was a general opalescence of the retina, and it appeared œdematous. From this he suspected renal derangement, and on the water being examined it was found to be slightly albuminous. The patient now travelled by railway, and an attack of hæmaturia was the consequence. She was put under proper treatment and the albumen disappeared, the vision gradually became perfect, and at the last examination the retina had resumed its natural condition.

The discussion at this point was adjourned until the next meeting.

November 10th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. A. E. DURHAM related a case where he had removed a portion of lint that had been accidentally introduced into the pleural cavity through an opening made for the evacuation of an empyema. The patient, a young man, æt. 19, came under the care of Dr. Wilks, in Guy's Hospital, on 22nd September, 1869. He had been ill some six or eight weeks, and presented all the signs of pleuritic effusion. The left side of the chest was much distended, and bulging of the intercostal spaces anteriorly was manifest. Mr. Durham introduced a medium-sized trocar and canula just above the sixth rib, about an inch below and rather to the sternal side of the nipple, and drew off about a pint and a half of pus. As the escape was not free enough during the next ten days, the opening was enlarged and a drainage tube introduced. The entrance of some air took place during the following day, and the pus not escaping very freely, the tube was withdrawn and the cavity kept open by a plug of lint soaked in carbolized oil. During the night of the 14th December the plug of lint was drawn into the chest by a violent inspiratory effort. The patient said "he felt it go right flop down on his heart." In the morning he felt it close to his spine. Mr. Durham introduced a pair of long, slender forceps of special construction, which he had designed for the removal of foreign bodies from the œsophagus, and using them probe-like, felt the piece of lint at the extreme posterior part of the pleural cavity. Opening the forceps he fortunately succeeded in seizing the lint at the first attempt, and withdrew it

without the slightest difficulty. From this period the man progressed satisfactorily, the opening was permanently established, and the pleural cavity daily washed out. The lotion being poured in, the patient having turned over, it was allowed to run out. On the 27th April the man left the hospital, but returned in October, 1872, three years after his first admission, having in the meanwhile followed his occupation as a shoemaker, and continued to wash out his pleural cavity almost as regularly as he washed his face. Only about three ounces of fluid were admitted; the chest had to a considerable extent recovered its normal dimensions. He was suffering from symptoms of amyloid disease of the viscera with albuminous urine, and although he left the hospital on the 11th December, yet he died soon afterwards. A post-mortem examination was not allowed. Mr. Durham called especial attention to the construction of the forceps he had used, and showed several modifications, all on the same general plan, and adapted for use on different parts of the body; and he stated that as far as he knew no other instrument had been yet designed with which the foreign body in question could have been reached and so easily withdrawn.

Mr. BRUDENELL CARTER related the case of a girl, *æt.* 17, who was shot in the chest. A large effusion of blood took place into the right pleural cavity, empyema ensued, and a drainage tube was passed; traumatic delirium then set in, and the tube, six to eight inches in length, slipped into the chest; a second tube was at once introduced and worn for two years. The patient then becoming insane was placed in an asylum, and the fluid was unfortunately again allowed to accumulate. On her discharge a third tube was introduced, and is being worn by the patient at the present time, who is doing domestic work, and during the last seven years there have never been any symptoms referable to the foreign body in the pleural cavity.

Dr. SYMES THOMPSON gave an instance of a gum elastic catheter seven inches long, which had accidentally slipped through an opening in the thorax, and which remained there without exhibiting any signs of its presence till the death of the patient, which took place about seven months after from exhaustion.

Mr. MAUNDER wished to ask why in empyema the pus always pointed at the upper and anterior part of the chest? It was most important to determine whether the best way to evacuate the pus was by means of a free incision, or by removing the fluid by a small

opening, at the same time taking care to prevent the entrance of air.

Dr. ROUTH said, he thought the indication was the injection of iodine or carbolic acid to set up adhesive inflammation.

Dr. SANSOM spoke very highly in favour of the aspirator.

Mr. ROYES BELL was averse to using the aspirator, and thought it a troublesome instrument. He thought the best mode of proceeding was to introduce a long probe from the front and, pressing against the intercostal space behind, between the eleventh and twelfth ribs, to cut down upon it, and passing a long drainage tube through the openings to tie the ends together, thus making any such accidents as had been related quite impossible.

Dr. CRISP suggested the plan of tying the tube to a piece of silk fastened round the patient's body.

Dr. WILTSHIRE said that the patient in Mr. Durham's case had died of albuminoid disease, dependent, in all probability, on chronic suppuration. He thought the important question was how to close the chest quickly, so as to limit the time of suppuration.

Mr. DURHAM, in reply, said that the pointing of the pus took place where it did, as at that point there was the least amount of physical resistance; he was in favour of keeping up a constant drain, and did not advise repeated tapplings. He then demonstrated a plan by which the drainage tube was made to fit lightly into the opening made by the trocar.

Dr. SYMES THOMPSON read the history of a case of

SCROFULOUS KIDNEY,

and showed the specimen. E. T—, æt. 38, thin and very pallid, a bootmaker, had been troubled with irritation of the bladder for three years, and had been thrice sounded for stone. A large tumour was felt in the left hypochondriac and lumbar regions, extending to within two inches of the umbilicus; it could be felt deeply in the lumbar region behind. The free margin of the tumour was rounded, and the hand could be introduced between the tumour and the margin of the ribs. It conveyed an obscure sense of fluctuation to the touch and was dull on percussion, except when covered by intestine. A fortnight before death large quantities of pus were discharged with the urine, micturition was frequent, and occasional streaks of blood were detected. The

tumour greatly diminished in size, and two days before death the veins of the left leg became painful and obstructed.

Autopsy.—The lung contained miliary tubercle. The left kidney now shown weighed 1 lb. 12 oz. It was adherent to the surrounding viscera which formed the walls of several large cysts, and on separating the organ a considerable quantity of greenish purulent matter escaped. The left ureter was thickened, but neither impervious nor dilated.

Dr. THOMPSON remarked that the diagnosis of this case afforded some interest. The extreme pallor of the patient, his tendency to faint on assuming the upright position, the freedom from heart mischief, or sign of extensive lung disease, together with the tumour on the left hypochondrium, suggested the idea of leucocythemia; but the blood showed no decided excess of white corpuscles, and the abdominal tumour appeared on deep palpation to extend far back into the loin and groin, and not so much beneath the false ribs as is usual with enlarged spleen. The diagnosis of pyelitis was soon confirmed by the discharge of pus with the urine; prior to this discharge the question whether the matter was in the kidney or in the neighbouring cellular tissue could not be confidently decided. From this time, however, there could be no doubt about the diagnosis, for besides the tumour, there was pain in the loins; frequent micturition with small quantities of blood, pus, tailed cells, and débris in the urine, ureter sometimes blocked with pus. The strumous aspect, phthisical family history, with developed, though not advanced, lung disease, were all confirmatory of the view that the case was one of suppurating tubercle in the kidney. In the absence of blood in the urine and cachexia the idea of renal cancer could not be entertained; primary tubercle of the kidney is less common than secondary in the proportion of four to one. In the latter both kidneys are always affected, and no symptoms are observed during life. Primary tubercle of the kidney is more common in children than in adults. A tumour was observed in about one quarter of the cases. Both sides are affected in about two thirds of the cases. The bladder and ureter rarely escaped. Of 31 cases described by Dr. Roberts, of Manchester, the lungs were also affected in 25, the abdominal glands in 13, the intestines in 18, the bones in 5, the peritoneum in 4, the spleen in 3, and the liver in 1.

Mr. BRAINE then read part of the minutes of the last meeting.

The PRESIDENT called attention to the fact that in albuminuria it was at times difficult to detect the albumen, but if the urine were allowed to stand for twenty-four hours and the lowest part of the fluid then examined, the presence of albumen would at once become apparent. He mentioned the fact that a gentleman who had suffered much from renal calculus had been for seven years before his death free from any symptoms. He remarked on the length of time the symptoms might last, and instanced a case where the patient's symptoms commenced when he was sixteen, and continued at intervals till he was sixty. Every now and then a large tumour formed in the right side of the abdomen, a free discharge of pus took place into the urine, and the tumour gradually diminished. This series of events took place a great number of times, and at his death, which took place from malignant disease, a large calculus was found impacted in the lower part of the right ureter.

Dr. CRISP mentioned the case of a gentleman who, while performing an athletic feat, was seized with sudden and severe pain in the lumbar region. The pain lasted three hours and then subsided altogether. After his death from heart disease, about a year afterwards, it was found that he had a renal calculus about the size of a man's finger; this was in two pieces, and doubtless the fracture had caused the sudden attack of pain.

Mr. DURHAM gave the particulars of a case in which he had removed the kidney, after having freely exposed it at a previous operation, and in which, although all the symptoms pointed clearly to stone in the kidney, yet the organ proved to be quite healthy, and no stone was detected anywhere in the urinary tract.

Dr. ROGERS spoke of the difficulty in diagnosing some of these cases. He narrated the history of a lady who two years after a fall had various abscesses and sinuses form in the iliac region and around the pelvis, leading to the belief that carious bone existed. During the whole of her illness there was no trace of blood, pus, or albumen in the urine, and it was not until after her death that the true source of the mischief was discovered. A calculus which had formed in the kidney caused suppuration, and was found external and posterior to that organ in a large abscess with which all the sinuses communicated. With the exception of one cyst in the kidney the whole of that organ was healthy.

Mr. CRIPPS LAWRENCE said he was present at the post-mortem examination of an infant, aged eight months, who had died of

pneumonia, and in whose left kidney a calculus of the size of a pea was found; the tubules of the mammillæ were also filled with uric-acid crystals.

Dr. FARQUHARSON threw out the suggestion that clots of blood following blows in the lumbar region were often the cause of renal calculi.

November 17th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

The following gentlemen were elected Honorary Fellows:—Prof. Virchow (Berlin), Prof. von Langenbeck (Berlin), Dr. Gueneau de Mussy (Paris), Dr. Duchenne (Boulogne), Dr. Ollier (Lyons), Prof. Chauveau (Lyons), Sir William Jenner, F.R.S., Sir James Paget, F.R.S., Dr. Arthur Farre, F.R.S., Dr. Burrows, F.R.S., Dr. Stokes (Dublin), Sir R. Christison (Edinburgh), John Hilton, Esq., F.R.S., Professors Owen, Tyndall, Huxley, Rokitansky (Vienna), von Scanzoni (Wurzburg), Hebra (Vienna), Helmholtz.

Mr. THOMAS BRYANT related a case of

INTESTINAL OBSTRUCTION.

Frances Collins, æt. 45, married, came under Mr. Bryant's care at Guy's Hospital, Jan. 18th, 1873. She reported that when in apparent health, four days before, while putting down a heavy bundle of wood, she felt something in her stomach give way. Vomiting at once commenced, and was accompanied by severe pain, extending all over the abdominal region from the pit of the stomach to the perinæum. Hot fomentations were applied and afforded relief, but the pain and the vomiting still occurred at intervals. The bowels had not been opened since the first appearance of the symptoms, neither had she passed any wind. She had a reducible femoral hernia in the right groin, which had existed for years. When seen, her abdomen was much distended, the tympanitic coils of bowel were made out through the parietes, and vermicular action of these coils being visible. Her face had a pinched and anxious look; pulse 120, full; urine scanty. The attacks of pain came on every

half hour, and she vomited a dark coloured, offensive fluid. No signs of femoral hernia existed, nor was there more abdominal tenderness at one spot than another. The whole history of the case, the suddenness and acuteness of the attack, clearly pointed to the presence of some mechanical intestinal obstruction, and it seemed likewise tolerably certain that the hernia had no direct connection with the symptoms. An exploratory abdominal operation was therefore determined upon, and an incision was made in the median line of the abdomen below the umbilicus about five inches long. Some coils of small intestine were then turned out upon the abdomen. All were injected but not dulled in their lustre, neither was there any lymph about them. A clear, slightly brownish serum flowed from the abdominal cavity; the small intestines were distended, but not to a great extent. Some of these coils were found to pass under a band, which consisted of omentum, and which was adherent below to the left ovary, the continuation of the bowel beyond the band was flaccid; it seemed clear that the bowel had passed under this omental band at the time she felt the pain on the 13th, and that it had become constricted by it. This band was tied in two places by a catgut ligature and divided; the edges of the incision were brought together by carbolised catgut ligatures, and strapping in broad bands was fastened all over the front of the abdomen; a compress of cotton wool was placed over all, and the patient kept fully under the influence of opium.

Jan. 19th.—She vomited once in the theatre after the chloroform, and again when she got into the ward. She had a two-grain opium suppository, and was afterwards subcutaneously injected with morphia. She seemed to be only drowsy from that time up to 10 p.m. She died at 3 a.m. the next morning, thirteen hours after the operation, without speaking again, although during the night she took a little fluid to drink from the nurse. After death, on opening the abdomen, the intestines and the omentum were found matted together. A coil of bowel, of a greenish colour and moderately distended, was found in the pelvis, bound down by a second omental band which existed as a narrow cord, and was attached to the right corner of the uterus. It was this band that had caused death. The obstructed bowel included six or eight inches of the ileum three inches from the cæcum. In conclusion, Mr. Bryant spoke in favour of exploratory operations.

The PRESIDENT agreed with Mr. Bryant in thinking that more

lives would be saved if the operation of gastrotomy was earlier and more frequently performed. Many physicians hesitated to recommend the operation, remembering how often patients with the symptoms described, although on the verge of death, were seen to recover without any operative measures being taken.

Dr. CRISP mentioned the case of a girl who for four days, in addition to the usual symptoms, had suffered severely with stercoraceous vomiting. Gastrotomy was performed, and a large quantity of whey-like fluid, with many flakes floating in it, was removed. The intestines were examined, but no constricting band was found. Another patient, who was frequently attacked with colic, always found relief by raising his legs and pelvis high in the air, making his head and shoulders the most dependent parts. One day, however, being attacked in the usual manner, this remedy and others failed to give relief, and death ensued. At the autopsy eight inches of the cæcum were found to be turned completely round, and this portion of the bowel was filled with blood.

Mr. MAUNDER said that, eight years back, the operation of ovariectomy was considered unjustifiable, while it was now frequently performed and fully recognised, and he fully thought that twenty-five years hence gastrotomy would be in the same position. He thought a good diagnosis was the chief element of success. He seldom tried opium for more than six or eight hours, and discontinued it unless marked benefit resulted, for after that time it only masked the pathological changes which were taking place.

Dr. PURCELL exhibited a kidney which contained a large renal calculus *in situ*. It was obtained from the body of a man, aged sixty-four, who died suddenly. The patient had been paralysed during the last eight years of his life, and had often complained of rigors and pain in the chest extending down his left arm. No symptom had ever developed itself sufficiently to warrant the diagnosis of such a calculus being present.

Mr. HAINWORTH remarked that he had noticed that in cases of suppuration of the kidney the patients generally complained of a sensation of constriction round the abdomen as if a cord were bound tightly round the waist.

Mr. SPENCER WATSON showed a patient on whom he had performed several operations for the relief of the deformity resulting from a burn on the neck and face. The contraction of the cicatrix in the neck had caused eversion of the lower lip, overflow of saliva,

and dragging of the cheeks and lower eyelids. In the first operation the sound skin on the side of the neck had been brought forward in the form of two triangular flaps, which were fitted into the gap, made by a transverse division of the contracted central line of the neck; complete union and a satisfactory result followed. In further operations the swollen and hypertrophied mucous membrane of the lower lip had been reduced by taking horizontal slips away from the inside of the mouth, and also by a third plastic operation on the prolabium by everting a portion of skin invaginated by the cicatrix. The boy, now aged eight years, can completely close his mouth, and has no overflow of saliva except to a very slight extent during his meals. The skin of the neck, which was drawn in a straight line from the chin to the sternum, now follows the curves of the under jaw and neck without any dragging upon the lower lip or cheeks. Mr. Watson, in illustration of the advantage derivable from the employment of two triangular flaps of skin, whenever a considerable gap was to be filled up, exhibited drawings of a case of ectropium in which a similar proceeding had been adopted with an equally good result.

Mr. BRYANT was sorry Mr. Watson had not supplemented his operation by grafting skin on to the raw surface which had been left by the removal of the good skin.

Mr. WATSON explained that the edges of the wound he had made came so well together that there was no raw surface left, on which to graft skin.

Mr. WILLIAM ADAMS read a paper on

THE GROWTH OF CICATRICES FROM WOUNDS MADE IN EARLY LIFE, AND THE SUPPOSED WEARING OUT OF SOME CICATRICES.

In reference to the growth of cicatrices four casts were shown taken from the feet of the same child at an interval of six and a half years, and proved that a cicatrix on each foot had grown during that time fully an inch in length. The wound was made by an operation for the cure of clubfoot, when the infant was ten months old, by cutting away the loose skin which could be pinched on the convexity of the clubfoot with a view of producing contraction by the cicatrix to overcome the inversion of the foot; no tendons were divided. Mr. Adams afterwards cured the case, when brought to him, by tenotomy. The child came under treatment again six and a half years afterwards in consequence of a partial relapse, and it was

then seen that the cicatrices had each increased fully an inch in length. The next case was that of a young lady who, when a baby a year old, was operated on by the late Mr. J. H. Green for the removal of a nævus by excision in the region of the breast. The scar left at the time was less than an inch and a half, but at nineteen years of age it was found to have increased enormously, measuring three inches in length, and varying from three quarters of an inch to an inch and a half in width. This no doubt depended on the growth of fat and the expansion of the skin in all directions by the development of the breast. The operation was preferred to the ligature because it was thought that a very small cicatrix would be left. These cases proved that when a portion of skin has been destroyed the cicatrix appears to be persistent through life, and to grow *pari passu* with the rest of the body, or rather with the portion of the body over which it may be placed. The increased size of the vaccination scars seen in the adult as compared with the scars in children, and also the large bald patches seen on the scalp of the adult when small nævi had been removed in infancy, were also alluded to by the author, who considered that care should be taken to make the wound as small as possible when operating upon children, and subcutaneous methods should be preferred. With regard to the supposed wearing out of some cicatrices, Mr. Adams believed that the only scars which do wear out are those which result from superficial cuts which do not penetrate through the deeper layers of the skin into the subcutaneous fat. When the deeper layers of the skin are divided, as in the lancet wounds of bleeding and in tenotomy operations, a gap is formed between the divided deeper layers of the skin, which retract in consequence of the abundance of yellow elastic fibrous tissue in its structure; lymph is then effused in the gap, and while fibrous tissue is forming the cicatrix structure is developed. Once formed this appears to be a permanent structure, growing as the part grows; and we have no evidence to show that it is ever absorbed or undergoes any process of wasting. There are two reasons for this permanence of cicatrix tissue: first, that the tissue is sufficiently well organised to be able to maintain itself in the general nutrition of the body; secondly, that the cicatrix tissue is so widely different from the structure of the true skin that it never can become assimilated to it, or resemble it either in the naked-eye or microscopic appearances.

Mr. BRUDENELL CARTER said that when his son was only five

years old he sustained a lacerated wound of the face, which extended in length from the angle of the mouth to the lobe of the ear, and at its deepest point it went nearly down to the buccal mucous membrane. Under chloroform he sewed up the wound with a number of very fine sutures, and the primary union which took place was perfect, the line of union being only just perceptible and about a hair's-breadth wide. The boy, who is now eight years old, has a scar seven millimètres in width, and the cicatrix has also grown in length.

Dr. CRISP showed the remains of a scar on his wrist from the bite of a rat. The wound was inflicted when he was ten years old. For twenty years he had two large and ugly scars; one had now quite gone, and the other was only just perceptible. He also showed a scar on his other wrist which had followed a penknife wound, and this scar had also very materially diminished. The scar he received from bleeding remains yet distinctly.

Mr. Jabez Hogg, Mr. Hainworth, Mr. Hemming, and the President also took part in the discussion.

Mr. ADAMS replied, and the meeting adjourned.

November 24th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Dr. SANSOM read a case of

MITRAL STENOSIS; CARDIAC HYPERTROPHY AND DILATATION; PRESYSTOLIC BRUIT; AUTOPSY.

A boy, *æt.* 9, came under observation at the North Eastern Hospital for Children, just after an attack of rheumatic fever, a similar attack having occurred ten months before. A presystolic bruit was discovered at the apex of the heart, and soon after admission pericarditis was manifest, which passed away, leaving only the original evidence of lesion. After much improvement another severe illness occurred four months after the former, and then were noticed extensive signs of cardiac hypertrophy, the presystolic murmur remaining as before. Ophthalmoscopic examination

showed fine retinal arteries with disproportionately large veins. The boy had many severe attacks of dyspnœa and pain, always relieved by digitalis administered either by fomentation or internally, and poultices of the leaves. He died thirteen months after his first appearance at the hospital, and twenty-three months after his first attack of rheumatic fever. The autopsy showed enlarged liver and moderate congestion of the other viscera, the lungs manifesting only a slight degree of hyperæmia. The pericardium was everywhere adherent. The heart was very large, weighing 12 ounces. The left auricle and ventricle were both much thickened, and the cavities enlarged. The mitral valve was funnel-shaped, with some roughening of the orifice. The aortic valves were very thick, but offered no impediment to the blood flow. The endocardium throughout the left side was thickened. The right cavities presented no abnormality.

Dr. SANSOM thought that this case confirmed the view of the auricular origin of the presystolic bruit; certain objections had been urged to the term presystolic, but it accurately defined the period of the occurrence of the sound. Looked at from the point of view of pathological causation, probably the best term which had been suggested for the murmur was "auricular systolic." In relation to time, however, and for the purposes of clinical demonstration, Dr. Sansom thought that the terms "systolic," "diastolic," and "presystolic," might be with convenience rendered into the English equivalents, first sound murmur, second sound murmur, and before first sound murmur. In the case mentioned the pathological conditions were confirmed, and the hypertrophy and dilatation were probably less the result of the valvular lesion than of the binding down of the heart by the pericardial adhesions.

Dr. FOTHERGILL was of opinion that the term presystolic murmur should be retained, for, in his experiments on the cold-blooded animals, he had shown that the auricles contract before the ventricles.

Dr. DOUGLAS POWELL thought that the best term to use was that invented by Dr. Hilton Fagge, viz. auricular systolic.

Dr. BROADBENT mentioned a case showing that the wrist pulse was absolutely delusive as a means of timing the contraction of the ventricles.

Dr. HARLEY and Mr. JABEZ HOGG having joined in the discussion,

Dr. SANSOM replied.

Dr. SANSOM then brought forward some

CASES ILLUSTRATING THE USE OF THE PNEUMATIC ASPIRATOR IN THE TREATMENT OF EFFUSIONS.

The cases occurred at the North Eastern Hospital for Children in the practice of Dr. Cayley and himself. Cases 1 and 2 were of a simple acute pleurisy. In Case 1, after an illness of ten days, 46 oz. of clear fluid were removed by pneumatic aspiration, and perfect recovery took place in eleven days. Case 2.—The aspirator was not used. After an illness of nine days the child came under treatment at the hospital, and in seven days the fluid, which distended the chest, became entirely absorbed. Cases 3, 4, 5, and 6 were cases of empyema. In Case 3, after an illness of rather more than eight weeks, 16 oz. of pus were withdrawn from the left chest by means of the aspirator. Eight days afterwards 12 oz. of odourless pus were removed in like manner; six days subsequently 14 oz. of thick pus were withdrawn, and some days after, 2 oz. more. After a lapse of fifteen days, 5 oz. of pus followed puncture of trocar and canula without aspiration. Free discharge took place, and the patient apparently recovered, but subsequently manifested signs of waxy degeneration of liver, spleen, and kidneys. In Case 4, after fifteen days' illness, 15 oz. of non-fœtid pus were removed by aspiration from the left chest. Ten days after 13½ oz. were removed. Recovery took place most satisfactorily. In Case 5 the empyema followed an attack of scarlatina eight weeks before; at the first aspiration only 1 oz. of pus was obtained. After an interval of four days 12 oz. were withdrawn, and thenceforward the child made a good recovery. Case 6 had been under medical care for eight months before coming to the hospital. Eight ounces of very fœtid pus were taken away by aspiration, after twelve days 8 oz. more were taken away, and great improvement followed. Six weeks subsequently there was pointing at the base, and exit was given to a small quantity of pus. The wound remained open, discharging for six weeks, when it closed and the child was in fair health. The next case was one of congenital hydrocephalus in which the removal of 4 oz. of fluid by the aspirator greatly relieved the symptoms. The state of coma which had been constant, and convulsions which had been frequent, were quite removed; but eleven days after the operation the infant died from diarrhœa. Post-

mortem examination showed no lesion as the result of puncture, but 8 oz. of fluid remained in the ventricles. In all the cases an excellent instrument made by Messrs. Krohne and Seseman was employed.

Mr. JABEZ HOGG then related the following cases :

1. ARRESTED DEVELOPMENT OF EYEBALL.

H. W—, 14 days old, came under treatment with a cyst as large as a good-sized walnut, covering the left eye. The history was, that it was congenital, but had increased considerably in size lately. On examination it was found that the left eyeball was entirely absent, a rudimentary stump occupying the orbital cavity. The cyst was tapped and pressure applied, but it again filled, and on the third day the operation was repeated. A week afterwards it had become larger and a seton consisting of two threads was passed through and allowed to remain for a week. There was considerable constitutional disturbance for a few days, but the child made good recovery eventually.

2. CONGENITAL MULTILOCLAR CYST IN THE NECK. AGED 14 MONTHS.

W. H—, the child of a consumptive mother, was brought with a swelling on the left side of the neck. Very soon after birth a slight enlargement was noticed and increased in size, and at the time Mr. Hogg saw it was as large as a goose's egg. The superficial veins were somewhat distended, the skin was thin but perfectly uniform throughout. The child ate and slept well. In the early part of December six threads of silk were passed through the cyst, in its longest diameter measuring about four inches. The cyst gradually emptied, became consolidated, and although at one time there was a good deal of constitutional irritation the child made a good recovery without the trace of a scar.

December 1st, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. H. CRIPPS LAWRENCE narrated a case of

INTESTINAL OBSTRUCTION FROM EXTENSIVE FÆCAL ACCUMULATION.

Mrs. S—, the wife of an Indian officer and the mother of four children, had from early life experienced much mental anxiety and bodily fatigue, having been a great traveller. She was naturally patient and hopeful, and exhibited great power of bearing pain. She had been subject to “biliousness” and constipation for some years, and had probably suffered from gallstones. Six weeks before the obstruction the kidneys had been congested, and during this time she had lived chiefly on milk.

On Oct. 18th last she complained of constipation, of four days’ duration, with sickness and distension of abdomen, and flatus, with pain referred to the right hypochondrium. The lungs, heart, and kidneys, with the respiration, pulse, and temperature, were normal; aperients were taken without effect. An enema relieved the transverse and descending colon of scybalæ, but the ascending colon was distended with fæces.

19th.—Acute pain referred to the right hypochondrium and right scapula came on and was relieved by opium. Enemata were given twice a day and the stomach kneaded by the hand, lubricated with oil.

21st.—All pain had ceased, but no action of the bowels took place; gr. iij of calomel with some Ext. Colocynth and Hyoscyamus were given followed by an aperient draught. No relief ensued and the pain returned. Half-grain doses of Ext. Opii were given and the kneading and enemata continued; and on the 23rd a copious, offensive, and variously coloured fæcal motion followed the enema; the patient, who before this had been unable to lie on either side, but especially on the right, could take rest on both, and the convalescence was speedy and complete. Mr. Lawrence instanced this case to point out the necessity of watching the assimilation of milk when large quantities of it were taken. His attention was drawn to

the fact by the case of a diabetic patient who was treated with large quantities of skimmed milk, and though somewhat relieved of the disease, yet faecal accumulation led to an obstruction at the junction of the transverse and descending colon, ending in fatal peritonitis. Enemata were considered in relation to composition and administration. Soft soap dissolved in water was recommended as having none of the disadvantages of oil as an ingredient, and as being equally efficient. When the accumulation occurred in the transverse or descending colon, the patient should be on the left side during the use of the enema; when in the ascending colon, the right side was preferable.

Dr. BROADBENT exhibited the heart and spleen of a patient who had died under his care in St. Mary's Hospital, one of two he had mentioned in the discussion on Dr. Sansom's case at the previous meeting; both were considered to have constriction of the mitral orifice. In one the presystolic or auricular systolic murmur was so greatly prolonged as to occupy the entire diastolic interval, in the other no presystolic murmur had been audible, but only a systolic tricuspid murmur; the latter was the case exhibited. The patient entered the hospital five weeks before, suffering from dyspnoea and other symptoms of heart disease. He was found to have bronchitis, and the only murmur heard over the heart was a loud systolic murmur. The seat of maximum intensity of bruit was near the ensiform cartilage, but it was audible at and beyond the apex and along the sternum to the base of the heart; it was not, however, audible in the back; jugular pulsation was visible in the neck. The systolic murmur was pronounced to be tricuspid, regurgitant and secondary to obstruction of the mitral orifice. The patient recovered so far as to wish to leave the hospital and resume his work; he was told that he was not yet equal to this, but obtained leave to go out for a few hours, and took advantage of his freedom from restraint to get drunk. He at once became worse, great congestion of the liver and ascites came on, followed by œdema of the legs. He was tapped early in the week with temporary relief, but became rapidly worse, and died November 30th. The mitral valve was found to be so narrowed as scarcely to admit a finger. The left auricle was enlarged and thickened, the right ventricle and auricle dilated and hypertrophied, and the tricuspid orifice dilated very considerably. The spleen was exhibited, to show some of the embolic patches common in this affection.

Mr. W. D. NAPIER explained

A NEW METHOD OF DETECTING AND TREATING VESICAL CALCULI.

He called attention to the number and variety of the instruments shown at the International Exhibition in testimony of the fact that a certain imperfection in the present system was felt by the great body of practitioners, so many of whom had devoted their attention to these improvements. He considered there was great uncertainty in the present method of discovering stone, and thought that further efforts were needed to make uncertainty more exceptional and relieve lithotomy from the complication which makes it, even when not dangerous, the cause of much suffering and the precursor of protracted recovery. He then showed an instrument called the "calculus detector." He had spent much time in producing this instrument and thought it was unique in its mode of action; it depended on ocular instead of aural proof. Similar in form to an ordinary sound, it is coated in pure lead from the commencement of the curve to its termination, and it is on the extreme susceptibility of this highly polished surface of lead to receive impressions on coming into contact with any hard substance that the author depends for the immediate detection of the presence of stone in the bladder. When, from any exceptional causes, the operation for removal has been delayed until a stone has attained to large dimensions, he deprecated the practice of lithotrity at all, and expressed his conviction that the patient's hope of recovery then lay in lithotomy; but in cases favorable to lithotrity he desired to prove that many or even most of the evils of the present system might be avoided in what may be termed the after-treatment. By means of the other instrument he had invented, called the "calculus extractor," he thought that present suffering and future complications may be greatly decreased. He enumerated several of the obstacles that at present come between the operator and a successful issue to lithotrity cases, such as distress to the patient from the presence of portions of stone too large to pass naturally, the premature repetition of the first operation that this renders necessary, and the abrasion of the mucous membrane, consequent on the withdrawal of the crushed fragments, which result occasionally in permanent stricture. The instrument he showed consisted of a delicate india-rubber tube, terminating in a funnel-shaped orifice resembling an ordinary

convolvulus flower, large enough to contain a calculus or a portion of a calculus of considerable size; it is capable of being inserted into the bladder by means of a silver canula in which it is enclosed, and when permitted to expand, on the withdrawal of the latter, it encloses in its folds any foreign substance that the position of the patient and the flow of the urine determine towards the natural outlet, and on the slightest attempt to draw it away it folds itself around any object or objects that have fallen into it, which, completely enveloped in its delicate elastic membrane, may be safely extracted without contact with the urethra, which is thus entirely protected from abrasion. He next drew attention to the temporary point with which the canula was fitted, which he hoped was a profitable discovery, not only in connection with this, but in every case where it is expedient to close the mouth of a catheter or canula. It is made of cocoa-butter, which has a peculiar property of dissolubility under a moderate heat, the sized point which he uses dissolving in a temperature of 96° in about a minute. It has also the further advantage of lubricating the passages through which it is passed. He concluded his notice of these instruments by pointing out the adaptability of the convolvulus tube to the purpose of a self-retaining catheter. He then gave a practical demonstration of the mode in which these instruments were used. A stone previously inserted in a preparation of the human bladder was first detected and then drawn out.

An animated discussion followed, in which several eminent surgeons took part, the objections raised being met by Mr. Napier with the assurance that they were such, as in the first instance had suggested themselves to him, but that actual application of the instruments convinced him that they were merely theoretical.

After free criticism, both favorable and unfavorable to the invention, the speakers severally concluded by complimenting Mr. Napier on the originality and ingenuity he had displayed in the construction of the instrument.

December 8th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. BRAINE showed a specimen of

CARVED RHINOCEROS BONE, REPRESENTING TWO
INCISOR TEETH JOINED TOGETHER.

Dr. SEMPLE read a paper entitled,

WHAT IS DIPHTHERIA? ILLUSTRATED BY A RECENT
EPIDEMIC IN ITALY.

The author in the first place gave a general sketch of the successive epidemics which have appeared in the world, that of 1856 and those of the following year being the most severe which had ever visited Great Britain. Until that time English physicians knew but little of the malady, and what they did know was derived from French sources. The researches of Bretonneau had contributed materially to diffuse a knowledge of its characters, but even now the true nature of the malady was not perhaps fully understood. At the commencement of the present century, viz. about 1818, the disease broke out as an epidemic in France, and then it spread to this country. The loose way in which the word "croup" was used, both by French and English writers, contributed very much to obscure the real characters of diphtheria, for while Bretonneau used the terms croup and tracheal diphtheria as synonymous, the English writers included under the name of croup at least three diseases, viz. tracheal diphtheria, laryngitis stridulosa, and laryngismus stridulus. Dr. Semple's own opinion was, that these three affections ought to be called by the above names, and then the word croup might be abolished altogether. Italy had very lately suffered from an epidemic of diphtheria, which recalls the former epidemics in that country recorded by Carnevale, Sgambati, Nola, and Ghisi, in the seventeenth century; but the Italian physicians of the present day are more fortunate than their predecessors, for they are well acquainted with the history of former epidemics, and, however dangerous and fatal the malady now is, the visitation is only a repeti-

tion of previous outbreaks in Europe and America. The recent Italian epidemic of diphtheria began in 1863, and then it somewhat declined till it broke out again in 1867; but it burst forth with greater vehemence in 1869, and reached its maximum in 1871 and 1872. The fearful ravages it committed may be estimated from the fact that in the year 1872 there were 1058 cases of diphtheria reported as occurring in Florence, of which number 563 died, and only 495 recovered. A committee of medical men had been appointed to take the whole subject into consideration, and to report upon certain questions connected with the outbreak. They had unanimously come to the conclusion that the so-called croupous form and the diphtheric form were only modifications of the same morbid process, and that laryngeal or tracheal diphtheria (generally called croup) was consecutive in the great majority of cases on the appearance of the disease in the pharynx. On questions of treatment the results were unsatisfactory, although local treatment was mentioned with a certain degree of approbation, and tracheotomy was considered at best a very doubtful remedy.

Dr. CRISP said that as regards treatment he believed the supporting and stimulating system was the best. In a former paper he had clearly proved that two thirds of the fatal cases of croup occurred in children under two years of age.

Mr. DURHAM said the difference between croup and diphtheria was not apparent in the post-mortem room; and though a deposition of fibrinous membranes took place in both, yet that croup was a simple local disease, while diphtheria was a severe constitutional affection. He regretted that the operation of tracheotomy was not performed early enough, and that the details in the after-treatment were often not sufficiently attended to.

Dr. HARE entered his protest against considering croup and diphtheria as one disease; the latter attacks adults, whilst croup is confined to children; and the treatment which is most advantageously employed in croup, is generally fatal, if used in cases of diphtheria.

Dr. BRUNTON said that in his opinion one of the chief points of difference between the diseases was that croup was neither contagious nor infectious, whilst diphtheria was both.

Dr. SEMPLE having replied,

Dr. FOTHERGILL read a paper on

THE DEPRESSANTS OF THE CIRCULATION AND THEIR USE.

Depressants of the circulation have been largely used in medicine, for the relief of febrile and inflammatory affections. The most direct of these, general bleeding, combined with antimony and opium, was for long considered the basis of treatment even so lately as the time of Hufeland. In 1800 Rasori conceived the idea of bleeding the sick person into his own vessels by the administration of large doses of antimony. After him, Broda used hydrocyanic acid for a similar purpose with good effects. In 1844 Fleming introduced to general notice a vegetable depressant, aconite. He found that it lowered the pulse in both rate and volume, and produced free perspiration, and he regarded it as a substitute for bleeding. Ringer regards it as a most valuable remedy, fully endorsing Fleming's statements, and is of opinion that many cases of commencing inflammation are cut short by its use. In the mean time the French school have brought forward two measures for affecting the circulation by external means, viz., "Jounodi's boot" and the "jacket poultice." The latter is an excellent means of relieving the circulation, for being applied to a large cutaneous area with its myriads of minute vessels, it dilates them, and actually bleeds the patient into his cutaneous vessels to the extent of their dilatation. The good effects of this in the treatment of pneumonia and the passing pulmonary congestion familiar to us all in the course of many heart cases, are well known. By means of these depressants several useful actions are induced—1st, the lowering of the temperature, by the cooling effects of a free flow through the cutaneous vessels, and by the cutaneous exhalations; 2ndly, the induction of sleep, associated with cerebral anæmia. The coincidence of sleep and perspiration in the crisis of malarial fever is well known; 3rdly, the removal of the evil consequences of a high temperature. These are obviated by the lowering of the body heat by the action of depressants, partly by the direct action upon the heart, partly by the effect on the cutaneous vessels; 4th, the starving of an inflamed area by affecting the general circulation; the vessels of the inflamed part being already paralysed.

Bouchut, in the '*Bulletin Général de Thérapeutique*' (April 15, 1873), puts in a plea for bleeding, which he finds to lower the temperature two or three degrees, and that too, very quickly. But the

depressants of the circulation may be utilised for other than the above purposes. Aconite is very useful in the treatment of congestive headache with cold hands and feet. Brunton found nitrite of amyl to relieve "angina pectoris," by dilating the peripheral vessels and so lowering the blood tension. Balthazar Foster found it to relieve "like magic" severe frontal headache with a high blood tension in a case of aortic valvular disease. Crichton Browne has found the calabar bean, which Frazer shows paralyses the cardiac ganglia, to be a most efficient means in the treatment of the wild paroxysms of general paralysis; not only so, but that it exercises a beneficial action over the progress of the case generally. In these cases there is usually a strong heart and great cerebral vascularity. Dr. Browne is also using nitrite of amyl in the treatment of recurring epilepsy with most encouraging success. Hydrate of chloral is a powerful depressant of the circulation, lowering the temperature markedly when given in large doses as well as producing sleep. In America, *veratrum viride* is being extensively used as a cardiac depressant in inflammatory and other conditions. *Veratrum*, aconite, and morphia relieve palpitation, not by stupefying the heart, but by acting upon the peripheral vessels, spasm of these vessels being commonly the cause of increased blood tension and embarrassment of the heart, the ventricle contracting with difficulty in the face of the obstructed blood flow. In much the same way potash and colchicum relieve the circulation in chronic renal disease. Ludwig and Traube regard the presence of histolytic products in the blood in excess, as stimulating the vaso-motor centre, and producing spasm of the peripheral arterioles. The elimination of these by potash and colchicum permits of the circulation becoming normal, and it is by this indirect action, probably, that they act so beneficially, rather than by their direct depressant action.

Dr. BRUNTON said he had experienced great pleasure in listening to Dr. Fothergill's very able paper, and he was sure he was joined in that feeling by all the Fellows present. He intended to make some remarks on the use of aconite, but as he was preparing a special paper for the Society on that subject, he preferred being silent till he brought the subject fully before them. As regards bromide of potassium in inducing sleep, he quite agreed with the author of this paper that it did produce anæmia of the brain, and on this principle he (Dr. Brunton) had treated a considerable number of cases of acute and chronic hydrocephalus with marked success. By

lessening the blood supply to the head, effusion was arrested, absorption increased, and cure resulted. He had published a paper in the recent number of the 'Glasgow Medical Journal' on this subject, with detailed cases.

December 15th, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. BRAINE read the minutes of Dr. Fothergill's paper (read on December 8th), and

Dr. WILTSHIRE read the heads of the discussion which, at the request of the Society, had been published by Dr. Fothergill.

Dr. FOTHERGILL then related the two following cases, which had occurred in the practice of Dr. Crichton Browne.

George S—, æt. 40, a pushing and successful man, of good physique and no family history of insanity, was admitted on the 12th October, 1872. He had most exalted ideas; as, for instance, that he would supply the earth with steam from one boiler. His pupils were somewhat contracted, and the facial muscles were constantly twitching; his tongue was tremulous, and the voice thick and husky.

Diagnosis — general paralysis. *Prognosis* — death within two years. *Treatment*—extract of physostigma gr. $\frac{1}{4}$ three times a day.

November 9th.—Had a paroxysm of paralytic furor. Extract increased to gr. $\frac{1}{3}$ ter in die.

11th.—Has had several attacks of pallor and vomiting; head to be shaved, and croton oil liniment rubbed in.

19th.—Decidedly calmer and better.

December 10th.—The patient is much better and quieter; sleeps well, and the hand is steadier; zygomatic muscles and tongue still shaky.

January 3rd, 1873.—Patient gradually improving.

February 12th.—Quiet and industrious. Repudiates all delusions. Twitching confined to lips and eyebrows.

May 2nd.—Quite rational and intelligent: no tremors.

July 30th.—Apparently quite well in mind and body.

August 31st.—Discharged, recovered.

Annie H—, æt. 37, a housewife, healthy, and free from any history of insanity, admitted July 4th, 1870. Brought to the asylum because she was excited and violent; a tall, stout woman, countenance florid and flushed, pupils very dilated and unequal; talks deliberately with shaking lips and occasionally lapses of words. Tongue tremulous; gait uncertain. Is mentally confused and bewildered; expresses herself as being very happy and never feeling better in her life.

Diagnosis—general paralysis. *Prognosis*—death in a year.

Treatment—liberal dietary and oxide of zinc.

November 25th.—Has gone down hill unmistakably. Ext. physostigmæ gr. $\frac{1}{4}$ ter die sumendum.

February 18th, 1871.—Has improved; is clearer in her mind and steadier in her muscles.

May 2nd.—Vomiting, with paralysis of left arm; cannot masticate or swallow. Pulse 110.

3rd.—Paralysis increasing; face flushed; skin hot and bathed in perspiration; sensibility diminished on the paralysed side.

5th.—Quite unconscious; retention of urine; bed-sore forming.

12th.—Power returning; some short convulsive seizures.

20th.—Restless and talkative; exalted ideas of a fragmentary character. Physostigma, which was stopped on the 2nd, to be resumed.

June 3rd.—Quite calm, but fatuous.

August 11th.—Patient has much improved.

21st.—Again vomiting; physostigma stopped.

29th.—Physostigma resumed.

September 20th.—The patient is gaining ground.

October 24th.—Able to sew neatly and walk steadily; tremulousness about lips and tongue still continues; ideas exalted.

January 28th, 1872.—Patient continues to improve; has had another attack of faintness and vomiting.

May 27th.—Improvement goes on.

December 14th.—Still improving; disease undoubtedly arrested.

May 7th, 1873.—No delusions; converses rationally, but somewhat childish; pupils still dilated; no muscular tremor.

20th.—Discharged, cured.

Dr. Fothergill remarked that physostigma not only lowers the

activity of the cardiac ganglia, but also renders them very susceptible to extrinsic impressions. Syncope is not uncommon in patients at Wakefield during their daily walks, while on a course of the bean. No unpleasant consequences have followed as yet. Dr. Forbes, at Shoreditch, has found the bean useful in the treatment of acute mania in its earliest stage. Both aconite and physostigma have powerful antidotes: belladonna and physostigma being antidotal, and digitalis and aconite.

Dr. LAUDER BRUNTON agreed with the views of Dr. Fothergill, but made a few remarks on some points, which were only slightly touched upon in the paper. It was difficult to see how purgatives could act as auxiliaries to bloodletting if they only emptied the intestine of its contents, by increasing its peristaltic action, as taught by Buchheim, Radziejewsky, and other German authorities. Their use at once became evident if the views of Moreau and Vulpian, that they increased the intestinal secretion, were adopted. By draining away part of the fluid constituents of the blood, they diminished the pressure within the vessels in somewhat the same way as bloodletting, though to a less extent. The speaker had repeated Moreau's experiments, and found that sulphate of magnesia injected into the intestine of a cat caused about two thirds of a drachm of fluid to be secreted in four hours by each inch of the bowel operated on, although the proportion of sulphate was only one grain to an inch. The effect of opium in inflammation was due, he thought, to its action upon the vaso-motor centre lessening the determination of blood to the inflamed part. Although congestion usually preceded inflammation, yet the two were quite distinct, congestion without inflammation being noticed in blushing, &c., while inflammation without congestion had been observed by Hollis in sea-anemones, which had no vascular system, and in newts' tails after their separation from the body. Congestion was shown by Sinitzin's experiments to be adapted for the restoration of injured tissues, but after inflammation had occurred it increased the pain, and probably proved injurious in many instances. Congestion was occasioned by an irritation applied to a sensory nerve, causing the vessels of the part to dilate, while those of other parts contracted and raised the blood pressure. The blood supply of the injured part, and the irritation of its nerves, thus kept up and increased the congestion in it. Opium weakened or destroyed the effect of a stimulus to sensory nerves, and by thus diminishing supply of blood

to a part afforded relief, just as raising the hand lessened the pain of an inflamed finger. He considered the beneficial effect of opium in peritonitis to be due to this action, and not merely to its keeping the bowels quiet. Not only was the vascular system capable of being greatly dilated by weakening or destroying the vaso-motor nerves, so that it could then hold more than twice as much as usual; but it could contract, so as to keep up the same tension on its contents after they had been reduced by bleeding. Vascular depressants which dilated the vessels, thus acted more powerfully and permanently, than venesection. Voit and Bauer had also found that bleeding increased the decomposition of the albuminous tissues, which was already too great in fever, and also lessened the combustion of fat. It thus increased the tendency to fatty degeneration. Aconite, on the contrary, lessened tissue change: for Dr. Meymott Tidy had observed that the tissues of animals poisoned by it retained their irritability for a long time after death; just as in cold-blooded animals, where tissue change goes on slowly; aconite had then a double advantage over bleeding, and probably other depressants had a similar effect.

Mr. BRUDENELL CARTER said that the contraction and dilatation of vessels were best demonstrated by the ophthalmoscope. He mentioned the case of a lad, at present under his care, in whom there was spontaneous pulsation of the retinal arteries; he suspected cardiac mischief, but none was found. The sphygmograph showed a high degree of arterial tension; that is, a general narrowing of the blood-vessels, and thus the boy's retina is being starved and the boy's vision is rapidly failing.

Dr. CRISP said that it was assumed by all present that arterioles and some of the larger arteries were muscular, but he had failed to find unstriated muscular fibres in the coats of the vessels, and he did not believe in their contractility. The speaker said he had carefully examined the death-rate for the last three decennial periods, and allowing for the increase of population, he found that the death-rate had increased in the following diseases:—Fever, scarlatina, measles, hooping-cough, diarrhoea, rheumatism, puerperal fever, and croup.

Dr. SANSOM said, that as in the investigation of disease objective were better than subjective signs, so in the investigation of remedies experimental data were better than unproven opinions. The old therapeutists had rested too heavily on mere opinions, and even now there

were probably many agents empirically employed which were destined to share the fate of the pulverised lizards and the decoctions of cerebral substance of ancient days. He could not, without close scrutiny of the data, accept the conclusion that modern medicine was practically less successful than the ancient. Most probably, from the advance in diagnosis, cases described as fever, croup, &c., in one epoch differed widely from those described in the other. The contractility of arteries and arterioles seemed to be so clear that he was surprised that any one could reasonably doubt it. In common with hundreds of others, he had observed it over and over again. Lister ('Phil. Trans.,' 1858) showed that by irritation of the vaso-motor centre such complete contraction of the arterioles of the web of the foot of the frog could be produced that it became white and exsanguined as if benumbed with cold. Dr. Fothergill, on one point, might have unintentionally produced an erroneous impression. He had spoken of a condition of narcotism as produced by a venous reflex with secondary arterial contraction, thence resulting cerebral anæmia. It might be interpreted that in his opinion this was the explanation of the production of narcosis generally. Dr. Sansom considered that narcotism might be caused by the obstruction of the cerebral arterioles at the periphery, as when blockaded by emboli or foreign bodies, or by active contraction of the arterioles, whereby the supply of blood was checked, or by dilatation of the arterioles whereby the blood-current was slowed. He had observed that the early action of anæsthetics was to contract the arteries, this was constant in the case of all anæsthetics discovered. Subsequently, however, and this more especially in the case of chloroform, dilatation occurred whereby the blood-current was slowed. In narcotism, therefore, the conditions varied; there might be arterial contraction, just as in the case of congelation or dilatation as in the advanced stages of chloroform anæsthesia; but there was one dominant circumstance, the imperfect supply of arterialised blood.

Dr. BROADBENT and Dr. THEODORE WILLIAMS having joined in the discussion,

Dr. FOTHERGILL replied, stating his belief that the veins themselves possess contractile powers, more especially those valveless veins of the portal system.

December 22nd, 1873.

S. O. HABERSHON, M.D., President, in the Chair.

Dr. FARQUHARSON read a paper on

CASES OF INFECTIOUS TONSILLITIS.

The variety of tonsillitis referred to in the paper, although generally recognised by practitioners, is not described in the ordinary text books, and therefore the author felt himself justified in bringing before the Society some account of an epidemic treated by him at Rugby a few years ago. A smart feverish attack invariably formed the starting point, headache, aching of the back and limbs, with general malaise, and a temperature running up to 103° , being the leading symptoms. Acute inflammation of the pharyngeal mucous membrane now followed, with pulpy thickening and an exudation of secretion from the orifices of the tonsillar follicles, and the contrast between these whitish masses and the vivid injection around was pointed out as a pathognomonic feature of the disease. Full convalescence usually resulted in a week or ten days, but the affection spread rapidly through the school, and had not prompt isolation reduced the number of cases to twenty, there seemed every reason to believe that a large proportion of the boys would eventually have been attacked. It seems quite certain that the nature of the morbid process had no connection with either scarlet fever or diphtheria, and although some resemblance can be traced to the *angines cournneuses* of Trousseau, there are essential points of difference, and we must consider the question as *sub judice*, why infectious properties were thus engrafted upon ordinary follicular inflammation of the tonsils. The indications for treatment were to soothe the affected parts in the first instance, and finally to brace them up by astringent applications; but it seemed a point worth noting, that suppuration was distinctly produced on three occasions by the premature use of nitrate of silver.

Dr. FARQUHARSON then read a communication, written by Dr. Pearson, on

AN EPIDEMIC OF SORE THROAT WITH MARKED CONSTITUTIONAL SYMPTOMS.

The paper described an epidemic of sore throat ushered in by rigors and smart fever, and giving rise to such constitutional disturbance as proved it to be of the nature of a blood disease, probably due to malaria. In strictly typical cases there was no exudation, but a secretion of glairy frothy mucus hanging about the fauces. The mucous membrane looked thickened, and the sub-mucous tissue appeared to be infiltrated, a condition which caused peculiarly sharp pain in swallowing, and much distress from the frequent compulsory acts of deglutition. The cervical glands became swollen and tender, with considerable œdema around them, occasionally resulting in suppuration, generally, in protracted pain and stiffness of the neck. The disease was evidently of a low type, the sudden and utter prostration of the patient indicating the attack of a blood poison upon the nerve centres. The fever symptoms resolved themselves in copious perspiration. In many of the cases albumen appeared in the urine, and in a small proportion hæmatin. Recovery was generally slow, patients being much weakened by the disease. In many instances a second attack followed the first, at an interval of ten to fourteen days. Over two hundred such cases had occurred in Kensington alone since the middle of August, beside a large proportion of cases modified by the previous tendency of the patient to follicular tonsillitis or to quinsy. Persons of all ages were attacked, and chiefly those in comfortable circumstances of life. The disease has been common in the parts of Mayfair skirting Hyde Park and very prevalent in the more open parts of Kensington and neighbourhood as far west as Chiswick. It has not been common in the more southern parts of Belgravia and Chelsea. It is not known at Islington, but appears again in the neighbourhood of Euston Square and Regent's Park, and in the open parts of Bayswater and Notting Hill. It thus seems to have an endemic as well as an epidemic character. It has only reached an epidemic character in those districts in which open spaces covered with grass and trees are found upon a gravel soil. The treatment found most suitable consisted of full doses of quinine, with the frequent use of a mineral acid gargle. Small bits of ice allowed to melt in the mouth proved at once serviceable and grateful to the patients.

In the discussion which followed,

Dr. THOROWGOOD said he had met with a good many cases of incipient tonsillitis in which the attack seemed to have been cut short by the administration of the ammoniated tincture of guaiacum and chlorate of potash.

Mr. LAWRENCE, of Chiswick, spoke of the value of isolation in these cases.

Dr. DOWSE read a paper on

CEREBRO-SPINAL MENINGITIS.

First drawing attention to the historical fact that Morgagni was the first physician to diagnose and define the symptoms of inflammation of the brain and its membranes; he then went on to speak of the epidemics of cerebro-spinal meningitis, or "spotted fever," more particularly the one which occurred at Dantzic in 1864; but the aim of the paper was to draw attention to the actual seat of lesion in sporadic, as contrasted with the endemic type of this disease, and this he endeavoured to do by narrating the history and pathological appearances of one out of several cases which he had had under his care. Dr. Dowse maintained that in its epidemic form the sensorium is more or less affected from the first, and that the membranes over the superior cerebral convolutions, cerebellum, and posterior columns of the cord, including the nerve substance, are primarily, if not wholly, the seats of lesion. On the other hand, he showed by clinical and post-mortem evidence that in the sporadic form the sensorium and special senses are only slightly influenced, and that the inflammation centres itself upon the meninges at the base of the brain and the anterior columns of the cord. He therefore felt justified in giving to the latter affection the name of occipito- or basic cerebro-spinal meningitis, in contradistinction to the former well-known disease. He drew his conclusions and diagnosis from signs and symptoms, as evidenced in the following table:

<i>Epidemic cerebro-spinal meningitis.</i>	<i>Sporadic or basic cerebro-spinal meningitis.</i>
Attack sudden, without any especial predisposing cause.	Attack commencing gradually, and resembling an onset of acute rheumatism.

Apparently of a contagious or infectious origin.

Sensorium affected from the first.

Excito-motor spasm of a tonic character in groups or groupings of muscles, with marked loss of cutaneous and muscular sense.

Reflex movements common.

Vomiting urgent and uncontrollable.

Temperature rarely exceeds 100° .

Purpuric maculæ diffuse and general.

Death usually takes place from coma.

Prognosis grave.

Post-mortem appearances reveal the membranes over the superior cerebral convolutions and posterior columns of the cord as the seats of lesion.

Usually arising from exposure to cold, exhaustion, and privation.

Sensorium never affected until the last stage.

In co-ordination of movement, with cutaneous formication, partial anæsthesia, muscular hyperalgia, but no tetanic spasms.

Reflex movements rare.

Vomiting not so severe.

Temperature often rises to 105° .

Maculæ never seen in the discrete form.

Death usually takes place from apnœa.

Prognosis hopeful.

Post-mortem appearances reveal the membranes over the base of the brain and anterior column of the cord as the prime seats of lesion.

In conclusion, Dr. Dowse, after laying down some important rules as to treatment, drew the observation of the Fellows to three points which he considered of interest for their consideration :

1st. In reference to the actual seats of lesion.

2nd. That the patient at the time of attack was suffering from primary syphilis.

3rdly. That the pathological condition of the membranes of both brain and spinal cord presented a most singular state of degeneration, viz. that of gangrene.

Dr. Crisp, Mr. Brudenell Carter, Dr. Farquharson, and Dr. Symes Thompson spoke on the subject of Dr. Dowse's paper.

MR. BRUDENELL CARTER showed a

NEW POCKET OPHTHALMOSCOPIC LAMP.

Mr. NELSON HARDY showed a case of

PERSISTENT PUPILLARY MEMBRANE.

Minnie S—, æt. 4 weeks, came under his care, at the Western Ophthalmic Hospital, on 9th December, 1873. On examining the left eye the pupil was found to be large, and it did not contract on exposure to a strong light. Remains of the pupillary membrane were visible in the form of fine filaments passing from the end of the iris towards the centre of the lens capsule, and when first seen these were connected with the iris by a net-like arrangement of loops; but when last examined, on December 19th, this reticular arrangement was fast disappearing. It seemed to represent the fibrous stroma of the sphincter muscle, from which the pigment and muscular tissue were absent. The mother states that when about three months pregnant she was frightened by a rat. From the appearance of the right eye, which was only rudimentary, it was evident that the arrest of development must have commenced subsequently to the end of the second month of utero-gestation, at which time the iris appears. It is said that the physiological use of this membrane is merely to preserve the shape of the pupil, but considering that it is only the front portion of a highly vascular membrane, which surrounding the lens as well as closing the pupil in the foetus, ventured to suggest that it might possibly have something to do with the nutrition of the sphincter of the pupil.

January 5th, 1874.

S. O. HABERSHON, M.D., President, in the Chair.

Dr. W. H. BROADBENT delivered his first Lettsomian lecture on syphilitic affection of the nervous system, the subject being

SYPHILIS AS A CAUSE OF DISEASE IN THE
NERVOUS SYSTEM.

January 12th, 1874.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. GANT brought forward the case of a young woman, æt. 29, from whom he had excised the antrum of the upper jaw for a

CYSTIC GROWTH.

About eight years ago she felt a small lump about the size of a Spanish nut high up in the left cheek; this increased in size, and she suffered from neuralgic pains in the face. When admitted into the Royal Free Hospital, the tumour presented a double swelling, partly in the cheek, and partly under the lip projecting down to the teeth. Mr. Gant then diagnosed the cystic growth in, and protruding from, the antrum; he made an incision from the nasal process of the jaw downwards, and carried it around the ala of the nose and through the middle line of the lip; the cheek was thus readily reflected and the tumour exposed. He then removed the whole of the antrum with cutting pliers from the second incisor to the last molar tooth, leaving the infra-orbital nerve above, untouched. The naso-labial incision was accurately closed with hair-lip pins. These were withdrawn on the fifth morning, union having taken place throughout the incision. The patient was shown to the Society, and now, two months after the operation, can speak distinctly, eat without inconvenience, and the face presents no disfigurement. The tumour when removed was apparently a fibro-cystic-growth, and the antrum had undergone expansion conformably to the growth, especially towards the nares, where the fibroid structure and the osseous wall were moulded together, but admitted of detachment. Mr. Gant suggested that the infra-orbital nerve should be preserved, as in the present case, by a little attention to the manipulative procedures.

Mr. SEWILL asked if a dentist had examined the mouth previous to the operation. Most of the cysts were of dentigerous origin. He exhibited some models illustrating the pathology of these cases. Removal of the offending teeth was often sufficient for the cure of these maladies.

Mr. BRYANT criticised the operation as having been more serious than

the disease required. He thought these cysts should be opened beneath the cheek, whether of simple or of dentigerous origin. The incision described by Mr. Gant was doubtless the right one for solid growths, but quite unnecessary in cysts of the upper jaw. He agreed with Mr. Sewill's remarks.

Mr. BRUDENELL CARTER asked whether Mr. Gant had heard of the operation lately performed by Mr. Warrington Haward, which consisted in completely raising up the whole face, which enabled the operator to remove necrosed bone from the nasal fossæ with the greatest facility.

Mr. GANT, replying, said the cyst was not dentigerous in the sense of having a tooth in it. With reference to Mr. Bryant's remarks, he would say that the disease was more a cystic growth than a cyst. He had repeatedly punctured cysts, but in this case he thought the removal of the bone itself was called for.

Mr. BRYANT after this qualified his remarks.

Dr. LICHTENBERG showed a patient on whom he performed a

RHINO-PLASTIC OPERATION.

The patient, æt. 16, had been suffering from lupus for ten years, had been treated without success at various hospitals, and when admitted into the Tottenham Hospital presented the appearance shown in the drawing he exhibited, having lost the entire cartilaginous part of the nose, with the exception of a minute portion of the left ala. Dr. Lichtenberg administered iodide of potassium without any good effect, and then performed the operation first introduced into this country by Professor Volkmann, of Halle. He removed the scabs in small scarifications of the excrescences, crossways, minutely chopping the diseased parts; a smart bleeding ensued, and cold-water dressings were applied. In about a week or ten days cicatrization took place in one spot, and in other places the disease appeared, sprouting up afresh. These parts were again attacked at an interval of about a fortnight, and the operation being repeated six times the disease was cured. On the 31st of last July he performed the rhino-plastic operation, taking the flap from the right side of the forehead; and here he warned future operators not to be too sparing in the size of the flap, as in this case the aquiline appearance of the nose was greater than he intended, as the alæ also were rather deficient in substance at the point of junction, especially on the left side, where a slight sloughing of the margin of

the ala took place. He was not successful in the turning in of the skin round the alæ, in order to prevent contraction of the nostrils, which he attributed to the portion of skin not being large enough. On November 6th he removed the knob of twisted skin together with a large part of the bridge of the nose by two oval incisions. This improved the appearance, and the septum, which was originally three quarters of an inch long, overlapped the groove, in the upper lid, to the right and left of it considerably. This he detached from the lip up to the groove on both sides, and having pared and thinned the naturally hypertrophied small flaps, turned them inwards towards the cavity of the nose, and passed through them a strong pin, made for the purpose, one end of which had a flat, broad head, and the other being constructed to screw up the septum to the tightness required. In three days the pin was removed and the operation was complete.

The PRESIDENT congratulated Dr. Lichtenberg on the excellent appearance of the patient; and

Mr. BRYANT, joining in these congratulations, said that it was most desirable not to spare the integument during the operation, and exhibited a drawing of a patient on whom he had operated with success. In this case the patient regained smell, which he had lost for many years; and he would ask, was this due to cessation of free exposure of the mucous membrane to the air?

Mr. BRUDENELL CARTER mentioned a curious case in which he found it necessary to encroach somewhat on the hairy scalp for flap, and in which the hair grew at the end of the nose until after the patient, a female, was married.

Dr. HUGHLINGS JACKSON brought forward, in conjunction with Mr. Brudenell Carter, a case of

DOUBLE OPTIC NEURITIS, IN WHICH VISION WAS PERFECT.

Mr. CARTER illustrated the case in one of the Society's ante-rooms.

Mr. SPENCER WATSON said, the optic nerve presented a remarkable case of neuritis. He asked if those parts of the retina not in the immediate neighbourhood of the optic nerve had been examined. Had Dr. Jackson any theory as to the nature of these cases?

Dr. HUGHLINGS JACKSON was not inclined to express any

confident opinion as to the way in which intra-cranial tumours and other adventitious products lead to changes in the optic nerves, but supposed that in many cases the changes resulted by vaso-motor action. As to prognosis in the case, he supposed the abnormal appearance would pass away, sight continuing. He had now seen recovery from a good many cases of optic neuritis, there being no amaurosis at any stage of it. He urged the use of the ophthalmoscope in all cases of severe brain disease, and especially when there was severe headache. He believed that severe optic neuritis with great deficiency of sight was more likely to result when much grey matter was affected by tumours. In every case of recovery from optic neuritis he had seen, very large doses of iodide of potassium had been given.

Mr. BRUDENELL CARTER said, the case brought forward belonged to a very interesting class, which ophthalmic surgeons seldom saw on account of the absence of any impairment of vision. But they saw many cases exactly similar in appearance, in which marked impairment of vision was present, as he believed, from the beginning; and it was a curious question in what the difference between the two classes consisted. The word neuritis was accepted, but he doubted whether there was sufficient ground for considering the state to be inflammatory; probably it was often the result of an impediment to the exit of venous blood, and was distension and varicosity of veins with consecutive oedema rather than inflammation. This condition, if limited to the internal or fibre layer of the retina, might not affect vision, unless the fluid contents of the eyeball were increased in a degree sufficient to compress the fibres and to impair their conducting power, or to compress the percipient nerve elements of the external layer. Possibly the difference between the two classes of cases might be essentially a difference of tension, but even in the former class sight was liable to be impaired, or even lost eventually, from the supervention of atrophic changes, possibly due to the shock to the nutrition of the parts, produced by the arrest of the circulation. As for the general state of the field of vision, its limits would always be curtailed when tension was much increased, and in the case just shown there must be scattered blind spots corresponding to the patches of hæmorrhage. Mr. Watson's suggestion about the normal blind spot was one that had often occurred to him, and some time ago he constructed a perimeter especially to examine into this point. He found, how-

ever, that the normal blind spot defied measurement, because the sensitive portions of the retina in its immediate neighbourhood became quickly exhausted and torpid to visual impressions. They thus were soon merged, so to speak, in the true blind spot, which appeared to increase in size in every direction as soon as the eye was a little tired. Besides this, there were only a few patients whose power of observation was sufficiently cultivated to enable them to watch their own sensations with accuracy.

Mr. ROYES BELL showed a patient the subject of

NECROSIS OF THE ORBITAL ARCH FOLLOWED BY EVERSION OF THE UPPER EYELID.

M. F—, æt. 16, was admitted into King's College Hospital, under the care of Mr. Royes Bell, with necrosis of the supra-orbital portion of the left frontal bone. She was seen first for a severe attack of erysipelas, brought on, according to her account, by a cold. Considerable sub-pericranial suppuration ensued, and free incisions were made to let out the pus. These eventually healed, with the exception of one over the left eyebrow, which has continued to discharge ever since. Three weeks ago she felt the bone move. A probe was passed along the sinus, and a great extent of loose bone discovered. Her general health was good. No headache; no strabismus. On September 13th the patient was placed under chloroform, and Mr. Bell having enlarged the sinus with his little finger, with the forceps lifted out a large piece of necrosed bone, which comprised the left supra-orbital arch of the frontal bone, from the external angular process to nearly the internal, extending upwards to the superciliary ridge, and backwards, involving a portion of the orbital plate of the bone. The wound healed rapidly, and the patient was discharged on the 19th September, six days after the operation, with directions to attend as an out-patient. This she failed to do, but came about the close of October, when the eyelid was drawn up, and slightly everted by the cicatricial contraction; but more by the falling in of the parts that had taken place. The contraction increased; and being readmitted on the 31st of October, Mr. Bell, the next day, made an attempt to remedy the deformity by dividing subcutaneously the cicatricial contraction, and introducing twisted wires to prevent the parts uniting as before. This was attended with partial success; and Mr. Bell made another incision over the cicatrix and dissected the tissues up, freely

dividing all the adhesions. The upper lid was kept down over the eye by passing three silver wire sutures through the margin of the dissected flap and integument of lower lid, and as soon as granulations showed themselves, small pieces of cuticle were transplanted from the arm. A pad was applied, and both eyes were kept bandaged.

November 20th.—Erysipelas of head and face.

December 17th.—Discharged, and has attended the out-patient room since.

Dr. WILTSHIRE showed, for Dr. Diver,

A DEFORMED FŒTUS.

Dr. Port and Mr. Henry de Méric were appointed to report on the specimen.

January 19th, 1874.

S. O. HABERSHON, M.D., President, in the Chair.

The second Lettsomian lecture was delivered by Dr. Broadbent, the subject being

SYPHILITIC AFFECTIONS OF THE SPINAL CORD AND MEMBRANES; OF THE PONS, MEDULLA OBLONGATA, AND CEREBELLUM.

January 26th, 1874.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. W. SPENCER WATSON read the report of a

CASE OF NEURO-PARALYTIC KERATITIS,

and exhibited the patient, a delicate, scrofulous woman, married.

After a fit with insensibility, had facial paralysis and deafness of the same side, with paresis of the fifth pair of nerves. Shortly afterwards some exposure to cold was followed by inflammation and ulceration of the cornea. Mr. Watson, who then saw the patient, treated her with tonics, and kept the eyelids closed by means of sticking-plaster. Under this treatment the cornea healed, and some amount of vision was retained. The lesion of the facial, auditory, and trifacial nerves, due no doubt to some intra-cranial deposit near the pons varolii, but not in it, was still persistent. Mr. Watson considered the case as confirmatory of Snelling's well-known experiments, and illustrated the necessity for three factors to cause the disease in the cornea: 1st, loss of sensibility; 2nd, loss of reflex irritability; 3rd, an external irritant.

Mr. BRUDENELL CARTER thought these cases depended more on the change in the nerve-tissue than on exposure of the cornea to air, dust, &c., and he was very strongly of opinion that they were generally of a syphilitic nature.

Dr. HUGHLINGS JACKSON showed a large coloured drawing, by Dr. Ambrose Kibbler, resident medical officer of the London Hospital, of the

OPTIC DISC OF THE RIGHT EYE OF A PATIENT WHO WAS THE SUBJECT OF AN OPHTHALMIC DEMON- STRATION

by Mr. Carter a few nights previous. It showed much swelling of the disc, many small hæmorrhages, and yet this was the point of the case: the patient could at the time the sketch was made (November) read the smallest test types as well as he can now.

Mr. SAMUEL JOHN HUTCHINSON brought forward a case of

SYPHILITIC NECROSIS AND ULCERATION,

showing the patient, and the artificial restoration of the lost parts. The disease had resulted in the destruction of the superior maxillæ (save a small part in the region of the antrum), the vomer, most of the ethmoid, all the spongy bones, and had also destroyed the soft parts, including the nose, some of the cheek, the upper lip, and nearly all the soft palate. A rhino-plastic operation being deemed impracticable, the case was treated mechanically. To supply the lost parts internally, an apparatus was constructed of vulcanite, bearing mineral teeth, which articulated with those of the lower jaw: it

was then held in position by the vulcanite being adapted to the whole of the inner surface of the nasal fossæ, thus affording a hold by means of suction. For the sake of lightness, the whole of the apparatus was hollow; the outer surface was coated with soft gutta percha, and rested successively on the following parts:—On each side, on the nasal wall of the antrum and the lachrymal bone; above, on the horizontal plate of the ethmoid; behind, on the basilar process of the sphenoid and the posterior wall of the pharynx; the floor of the artificial piece formed the roof of the mouth. Mr. Hutchinson had also made an artificial nose of vulcanite. This was fixed to the man's face by an elastic band which passed round the head; the junction was, passibly, hidden by means of a moustache fixed to the upper lip, which was also artificial. Mr. Hutchinson commented on the fact that the man's occupation—he was a mason—and his position in life, compelled him to treat the case in the simplest manner possible, the various delicate improvements in the shade of colour, mode of attachment, and usefulness in mastication, being only possible in the case of persons in a higher sphere of life, who would appreciate, and practise, delicacy of manipulation. The patient's residence in a remote part of Wales precluded any but the most practical treatment, and that least likely to get out of order. He also pointed out the interesting fact that the sense of smell was present while the artificial nose was worn, but was entirely absent when it was not applied to the face.

Mr. SEWELL described a mechanical contrivance for the relief of cleft palate.

Mr. PENNEFATHER showed some specimens of aural polypi, and a new instrument for removing them. He also showed a very ingenious instrument for introducing an artificial tympanum.

The report prepared by Dr. Port and Mr. Henry de Méric, on the deformed fœtus sent by Dr. Diver, was then read by Dr. PORT, and was as follows:

The cranium and the spinal canal are fissured in their whole extent; of the spinal cord nothing at all could be distinguished; of the brain, only rudiments which adhered to the torn sac formed by the meninges. On the other hand, all the cranial and spinal nerves were well formed; no other malformation could be found out, except those dependent on the abnormal accumulation of cerebro-spinal serum. The gentlemen who saw the fœtus a fortnight ago must have been struck by

its curious shape, the face turned upwards, the large eyes, the backward inclination of the forehead, the well-developed jaws, the neck arched forward, giving to this monster the appearance of having a large goître. We have cut out the skull and spine to show which were the anomalies in the skeleton that brought about the before-mentioned deformities. You see that the flat bones of the skull hardly exist; that the basis of the cranium is very much shortened, and that there is a strong flexion between the pterygoid bone and the os occiput. It looks as if the upper part of the cranium had been sawn off, at the same time the base is not concave, but rather plane and even slightly convex. Of the frontal bone the nasal portion is well developed; of the frontal part there is only a small margin to be seen. We could not detect anything of the parietal bones. The pterygoid bone is extremely small; the petrosal bones are comparatively large. The only existing part of the occipital bone is its basilar portion. If you regard the open cavity of the skull, as a whole, it seems as if a force had acted from within in all directions, had torn asunder part of the cranium, and partly destroyed the bones or shifted them sideways. The spinal canal is freely exposed, there being no posterior arch; it does not look like a semi-canal, but is plane. The spine regarded as a whole shows a strong curvature, the cervical part being much turned forwards, the upper dorsal backwards. At the same time the cervical vertebræ seem to have been arrested in their growth. Among the malformations that are brought about during the foetal life by abnormal accumulation of the cerebro-spinal fluid there are three species to be distinguished. In the first, there is an abnormal quantity of serum, but the brain, spinal cord and its bones remain closed (hydrocephalus, hydrorrhachis). Secondly, there is a permanent accumulation of serum at certain parts, and then the canal gets fissured and the brain or cord prolapses (hydrocephalocoele, hydromyocoele). Thirdly, the original accumulation of serum was so great that the consequence is, a permanent fissure of the whole cerebro-spinal canal, with more or less destruction of the brain and spinal marrow (cranioschisis, rachischisis). Our case belongs to the last.

The PRESIDENT then showed

A HEART WITH AORTIC DISEASE, ONE OF THE VALVES BEING THICKENED AND EVERTED.

The patient, a butcher, æt. 19, had suffered from acute dropsy, pericarditis, and double pleuritic effusion, and on July 15th the dyspnœa was so urgent that paracentesis was performed in the sixth left intercostal space, and about three pints of serum removed. There was gradual improvement up to the 12th August, and on the 19th the patient went to a convalescent hospital. On leaving he went back to his work, and continued better in health till three weeks ago, when he had sore throat. He continued at his work for another fortnight, when pain in the region of the heart and on the right side of the chest, and also in the left arm, came on, accompanied with great dyspnœa.

On admission he had a pale and anxious expression, and there was urgent dyspnœa. The abdomen was full and tense, and the hepatic dulness had increased. There was continued cough, especially at night, sputum thin and frothy. The breath sounds were normal, the cardiac dulness extended from the fourth to the sixth ribs. A distinct double bruit was audible over the aortic valves, and in the course of the aorta, but at the apex of the heart and to the left of the nipple it was difficult to distinguish the precise time of the cardiac murmur; a soft systolic murmur was synchronous with the cardiac impulse, and was followed by a louder bruit. The latter sound was thought by some to be synchronous with the pulsation of the carotid. The pulse was regular, 116; respiration 60; urine 34 oz., sp. gr. 1016, free from albumen and sugar. Infusion of digitalis 3j, in the carbonate of ammonia mixture, and a small quantity of brandy was given.

On the 1st of January he did not sleep on account of the flatulent distension of the abdomen, but there was less cough and less pain; pulse 116, respiration 56, temp. 99.6°. Ether with spir. chloroform. and mist. camph. were given.

On the 6th he had not improved. Resp. 64, pulse 128. He was ordered tinct. digitalis and mist. senegæ (Guy's phar.). On the evening of the 9th he was better than usual. He had been playing at draughts, and went to sleep comfortably, but awoke about 10 p.m., in great distress, breathing most difficult. Resp. 100 per minute. He died the following morning.

Autopsy on the 10th. There was some effusion into both pleural cavities to the amount of one or two pints; lower lobes of the lungs red, fleshy, and compressed; the pericardium adherent. Aortic valves, one valve thickened and everted, the double crescents much

thickened, ventricle dilated and hypertrophied ; mitral not enlarged ; some small vegetations on the auricular side ; weight of heart 19 oz. ; liver congested and fatty, 63 oz. ; spleen firm ; kidneys congested.

February 2nd, 1874.

S. O. HABERSHON, M.D., President, in the Chair.

The third Lettsomian lecture* was delivered by Dr. Broadbent, the subject being

SYPHILITIC AFFECTIONS OF THE BRAIN, MENINGES,
AND CEREBRAL ARTERIES.

February 9th, 1874.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. MORGAN, of Dublin, read a paper on

A FERTILE SOURCE OF VENEREAL CONTAGION, DEMONSTRATED
BY EXPERIMENTAL RESEARCH AND DIRECT PROOFS,
ILLUSTRATED BY MODELS AND DRAWINGS.

In speaking of the results of the Contagious Diseases Acts, Mr. Morgan said that the results of their adoption had been to cause a very marked diminution of the disease in those districts protected by them. The War Office Return of 1872 states that the percentage of soldiers diseased has fallen from 108 per 1000 to 54 per 1000 in the protected districts, while in the unprotected the percentage has increased to 123 per 1000, and it is a most remarkable fact that in the protected districts, the disease is of a milder character, or in other words, that in these districts the soft or chancreoid sore has replaced to a great extent the true or chancre sore. The author then

* These lectures were published in the 'Lancet' and 'British Medical Journal' of 1874.

called attention: 1. To the working of the Contagious Diseases Acts. 2. To the explanation of the attainment of the milder form of the disease by the enforcement of the Acts. 3. To the question of the duality of the venereal disease. 4. To the possible curative tendency of the introduction of a milder form of the disease by artificial means. He pointed out that the great source of the propagation of the milder forms of the venereal disease was the inoculation by contact of the vaginal discharge (muco-purulent or purulent, as the case might be) of women when suffering from a syphilitic taint. He had been forced to this opinion from the result of a large number of testings he had made. These were performed by means of inoculation as practised by Ricord, and the virus was taken, not from the sores, but from the vaginal discharge of patients in whom no sore was discernible, and who had been weeks and even months confined to the hospital, so that the possibility of recent infection with soft sores was impossible. The patients had all been over and over again examined with the speculum. It might be said by some that only those patients who were already syphilitic were tested, and such was the case, for it was clearly inadmissible to inoculate a healthy person, and it was shown that the result of the inoculation of the vaginal discharge was, as a rule, much more active and more intense than inoculation with matter taken from the primary sore or its resulting pustule, and he inclined to the opinion that the frequent occurrence of the soft sore in the male is explicable by its being a derivative of syphilis proper or a modification by descent, and one which leaves the system in very many cases unscathed. He believed in the unity of syphilis, but that it was capable of modification by descent, and that the non-infecting sore so frequently followed a definite course, as practically, in the male, to constitute a distinct disease and require a different treatment. In the Dublin Lock Hospital, on the female side, less than ten per cent. of the sores were indurated, yet fully ninety-five per cent. of the patients suffered from constitutional signs. He had recorded, accurately, ninety-one cases of primary disease, as the patients entered the hospital. He auto-inoculated ten, all had constitutional signs; of four auto-inoculated and who had bubo, all had signs; three, auto-inoculated, had none before leaving; the remainder were not auto-inoculated, and five only out of the ninety-one had induration. In reply to inquiries made by the author, the surgeon of the Curragh Lock Hospital stated that, "any and every form of primary sore, whether

with or without induration, may be succeeded by constitutional signs. Induration in the female is exceptional." The surgeon of the Cork Lock Hospital for females, stated, "I have not met with more than two or three sores which could be considered in any way indurated; in fact, they all had the character of the soft sore." Attention was next drawn to the activity of the vaginal discharge, or the muco-purulent secretion of *syphilitic* females, in producing the inoculation pustules. In the patients from whom this discharge was taken sores were carefully sought for by the speculum, and as some of the patients had been under strict hospital *régime* for two or three months before the inoculation test was put in practice, the existence of an internal sore must have been all but impossible. The comparative disappearance of the hard and infecting sore in protected districts was also explicable if it was remembered that the result of the inoculation of the vaginal discharge of syphilitics on syphilitics was the production of a sore which conducts itself as the chancroid, with its comparative constitutional non-infection, and we may fairly conclude that, if communicated to a non-syphilitic male, it should result similarly, and though it is derived from a syphilitic stock, it is so modified by descent as usually to expend itself locally. Mr. Morgan said he had frequently tried the secretion from mucous patches, and, as a rule, failed, though he had succeeded in the young, and produced a sore of the same chancroidal aspect. He had not tried the pus of an ordinary abscess or other source, as, though he would not have any hesitation in using the specific pus of syphilis or of gonorrhœa, he would shrink from using that from ordinary sources, fearing, what must be admitted to be, the mystic dangers of pyæmia. The writer had inoculated gonorrhœal matter in six cases, and failed to produce a pustule in each case, and therefore he drew the inference that it was not any condition within, but clearly outside the patient, which led to the formation of the specific pustule and sore capable of reproduction in its kind, and capable of becoming the scolex or head of an endless reproductive chain, each joint of which is in turn (when cast off) capable of becoming the head of a series. The author concluded his paper, which was fully illustrated by models in wax, diagrams, and printed notes, by observing that he did not argue in favour of the adoption of the inoculation cure, there being many arguments against it on the ground of inconvenience, repulsiveness, and uncertainty; but when it seems evident that from an intensely tainted and syphilitic source,

the milder and usually admitted harmless variety of sore can be obtained, it may yet form the basis at least for a possible and rational line of treatment.

Mr. ACTON felt personally indebted to Mr. Morgan for coming forward this evening and demonstrating the advantages of the Contagious Diseases Act in Ireland. Surely if vaginal discharges were so easily inoculable, it was an additional reason why women suffering under these affections should be compelled to enter hospitals and remain there till cured. Mr. Morgan had assumed that a woman suffering under secondary syphilis was liable, necessarily, to an inoculable vaginal discharge. Mr. Acton would appeal to those having the largest experience, and ask them whether they would not corroborate the opposite belief that pure uncomplicated secondary syphilis was, on the contrary, generally unattended with vaginal discharges. He (Mr. Acton) would therefore maintain that a discharge from the vagina need not necessarily arise from secondary syphilis. When studying inoculation in the wards of the Parisian hospitals, he was accustomed to collect the secretion of primary sores, and keep it in close tubes. It acted almost as well at the end of considerable periods of time as did fresh-collected virus. It was in those days a well-ascertained fact that if syphilitic poison was placed upon the sound skin or upon a mucous membrane where the epithelium was uninjured, no effects would be produced. Mr. Acton, therefore, did not look on the constitutional symptoms of syphilis as the cause of the inoculability of Mr. Morgan's vaginal discharge; but believed that the success of his inoculation depended upon the deposition on the vagina of secretion of a primary sore coming from an infected man, and which secretion had not been thoroughly washed away, although the woman may have been in hospital some weeks. No one unacquainted with the numerous sources of error that may occur in the investigation of inoculation could believe in the various sources of error met with in practice. Without absolutely denying the contagion of secondary symptoms, no doubt could exist, that positive evidence was still wanting, corroborating the statements that all parts of secretions of secondary symptoms were highly contagious. Primary syphilis was undoubtedly a very inoculable disease; but Mr. Acton had yet to learn that the secretion from secondary syphilis was an easy medium of communicating the affection from one individual to another. His own private practice led him to no such conclusion. He (Mr. Acton)

was now only occupied in private practice. Under such circumstances statements could be well observed, tested, and corroborated by personal observations, and these did not tally with the opinions of some modern writers who appeared to have collected their cases at dispensaries, or among the out-patients of hospitals. The statements of these patients were often misleading. He had been taught in the wards of Ricord to test in every conceivable way facts as they occur in practice. There, nothing was taken for granted, and everything connected with the subject was treated as doubtful till tested. In some cases misstatements were to be attributed to ignorance ; in others, deep cunning existed, which had to be probed. In private practice it must be remembered that we often have to do with an intriguing woman, a scapegrace of a man, a lying nurse, and a child unable to speak. With these uncertain data, we have the further sensational items of adultery, seduction, and illegitimacy. Yet there are among us those who, without much personal experience, profess to be able at once to decide upon the most complicated cases. It was impossible in a discussion like the present to enter upon the abstruse questions started in the paper, and he should prefer carefully examining the cited cases before coming to any conclusion on the results to be drawn from them.

Mr. HENRY LEE said that the Profession and the Society must be deeply indebted to Mr. Morgan for having taken so much pains, and for having undertaken so long a journey to bring under their notice a very remarkable series of facts. That they were facts he (Mr. Lee) did not doubt, and they were, in fact, partly confirmed by his own experience. He had inoculated the secretion from the mucous membrane of a syphilitic patient, and produced what appeared to be a specific pustule. But then came the very important question, whether the results of all syphilitic inoculations were the same. Now, in order to clear up this subject, these inoculations must be observed in uncomplicated cases ; and here he (Mr. Lee) believed Nature would always be true to herself, and would, under the same circumstances, always give the same answer to the same question. The secretion of the local suppurating sore, if inoculated, would always, when uninfluenced by any other action, produce a strictly local disease. The inflammation would not extend beyond the immediate neighbourhood of the inoculated point ; a pustule would form, accompanied by loss of substance, and a well-defined circular pock-mark would be left. On the other hand, if the secretion from

a real syphilitic affection were inoculated upon a patient who had not previously had the disease, some local irritation might follow, but the real effects of the poison would not manifest themselves until after the lapse of some days, and then would appear one of the well-known forms of the primary manifestations of the constitutional disease. But if this same secretion from a syphilitic patient were inoculated upon a patient who had at the time constitutional syphilis, then the sore which resulted might have no period of incubation, and would probably be unaccompanied by any induration either at the seat of the inoculation or in the corresponding inguinal glands. It would be modified by the existence of previous disease, and that disease might be roused into action not only by the inoculation of the secretion from a syphilitic patient, but from the inoculation of common pus. He (Mr. Lee) had shown to the Society last year a very well-formed pustule, accompanied by some amount of ulceration, which had been produced by inoculating the pus derived from a case of excision of the knee-joint in a child. The inoculation was, however, made on a syphilitic patient, and the virus was not in the pus inoculated, but in the patient inoculated. Now, in all Mr. Morgan's cases the experiments were performed upon patients already syphilitic, and therefore there was the twofold action of the virus inoculated, and of the disease already in progress in the patients' systems, and in accordance with this twofold action the results which Mr. Morgan had demonstrated by the casts and drawings before the Society were very different from those which he (Mr. Lee) had seen as the result of the inoculation of the secretion of the local suppurating sore upon patients who had not previously had syphilis. In Mr. Morgan's cases, as illustrated, there was a halo of inflammation extending a considerable distance from the seat of the puncture; there were in several cases irregular and somewhat extensive superficial ulcerations; and in one case a well-formed pustule had been formed within twenty-four hours. These results differed, he repeated, very materially from those of the inoculations from the simple suppurating sores, and the difference must be attributed to the twofold action which was set up. Mr. Morgan had proved that the secretion from the vagina was inoculable. Now this might be the only secondary manifestation in a syphilitic woman, and he (Mr. Lee) would ask Mr. Morgan whether any amount of physical examination would enable him to say whether any given patient

under those circumstances was syphilitic or not if she had well washed herself previously to being examined? Mr. Ricord had formerly laid it down as a rule that no patient could contract syphilis except from a primary syphilitic sore; and many cases of most cruel injustice had happened in consequence. A man who had syphilis before his marriage sometimes found that his wife became subsequently diseased. Acting upon the opinion given by Ricord and those who followed him, and being not only accuser, judge, and jury, but also sometimes the author of the mischief, he treated his wife, upon the medical evidence alone, as if she had been unfaithful to him. Mr. Morgan had now shown, experimentally, that which he had long upheld—that the secretions from a syphilitic person, whether accompanied by an open wound or not, would communicate constitutional syphilis. Mr. Lee concluded that the illustrations given by Mr. Morgan were examples of syphilitic inoculation modified by the patients upon whom the inoculations were made being syphilitic at the time; and that the effects produced differed in their essential characters both from those produced by the inoculation of the secretion from a local suppurating sore and also from the results of the inoculation of the products of secondary manifestations in uncomplicated cases.

Mr. DE MÉRIC stated that the Society could not be but grateful to Mr. Morgan for the trouble he had taken in coming to lay his important experiments before them, the inoculations being so carefully and artistically illustrated. Mr. de Méric was well acquainted with them from perusing Mr. Morgan's book, which testifies to an enormous amount of labour and persevering research. Yet the inference drawn from the numerous experiments was open to criticism. He would first allude to one of those experiments in which it was sought to prove that the chancroid may have a long incubation. Here an inoculation was followed immediately by a pustule, and sixteen days afterwards by an ulcer. Now there was no incubation here; the pustule was evidently the positive and rapid result of the inoculation. Passing on to the principal portion of the paper, we find that one of the main assertions of the author is the frequency of the indurated sore in men and its great rarity in women. This is a pretty common belief, which has, however, been rectified by Fournier, who, like Mr. Morgan, writes from a Lock Hospital for women. M. Fournier, in his admirable lectures, had numerically proved that the proportion of hard sores in women is pretty considerable. He (Mr. de Méric) had, in his hospital practice, seen a

good many of these hard sores in women. Now, it would seem that Mr. Morgan was struck by this supposed disproportion, and asked himself, whence the male portion of the population took their hard chancres; and hence the numerous and highly important inoculations with vaginal fluid which the author of the paper had undertaken, and which place his name by those of Carmichael and Wallace. And here the evident leaning of Mr. Morgan towards the doctrine of unity must be mentioned, because the value of the inoculations just mentioned rests on the belief in that doctrine. The author of the paper is inclined to think that the infecting chancre and the chancroid are derived from the same virus; and he draws the conclusion that the chancroids which he produced with the vaginal discharge upon patients already suffering from syphilis would have turned out hard or infecting chancres had the subjects, upon whom the inoculations were undertaken, been in a perfectly healthy condition. To this, however, all those professing dualistic opinions must demur. Granting that the sores produced by the vaginal discharges were really chancroids, which a previous speaker (Mr. Henry Lee) had questioned, it does not follow that on healthy people true chancres would have been generated. Mr. Morgan actually thinks that syphilis proper can be communicated by such discharges, and at once applies this hypothesis to the Contagious Diseases Acts, insisting that inspectors should pay considerable attention to the leucorrhœal state of the women brought under their notice. That a chancroid, however, existing upon a patient already suffering from syphilis might convey the latter disease, was a melancholy fact, an example of which Mr. de Méric had seen in his own private practice. The case will be found in the 'British Medical Journal,' January, 1874, and alludes to a gentleman who had had syphilis before his marriage, and conveyed no disease to his wife and children for twelve years, when he contaminated the former by means of a soft chancre. Mr. de Méric was sorry to find that Mr. Morgan, on the plea that there was *something* in the inoculations he had performed, during which the syphilitic symptoms of the patients seemed to have diminished, was inclined to put some faith in the curative powers of such inoculations. Boeck's system had been condemned in this country by the very surgeons who, at the London Lock Hospital, had powerfully assisted him in his experiments; and it is to be hoped that such men as Mr. Morgan will not lend the weight of their name and reputation to a practice which is both repulsive and ineffectual.

Dr. CHARLES R. DRYSDALE said he had long been familiar with Mr. Morgan's work on syphilis and with the important experiments referred to by the author, which he (Dr. Drysdale) considered to be unassailable. He had himself made some attempts to verify Dr. Morgan's conclusions, and had inoculated female patients affected with syphilitic eruptions on four occasions from their own vaginal secretions. In three of these cases no result took place; but on the fourth a pustule was produced under the right breast, quite similar to those he was accustomed to see during the numerous inoculations made by Professor Boeck when in London. He therefore thought it most highly probable that such vaginal secretions in public women might, in numerous instances, produce both syphilitic and ordinary sores on healthy men. The question of *duality* was more a practical one than a theoretical one. In the male, he used to notice at the Midi Hospital of Paris that perhaps four-fifths of the sores seen could be distinctly called soft or hard; but even then, as Mr. Morgan said, the prognosis as to the appearance or non-appearance of syphilitic eruption was sometimes doubtful. It seemed to him that Mr. Morgan's experiments explained well the great uncertainty observed to obtain as to the results of confining women in hospitals under the Contagious Diseases Acts. Syphilitic secondary eruptions lasted usually eighteen months or two years, and during all this time it was likely, according to Mr. Morgan, that vaginal discharges in syphilitic women might infect; so that, in order to prevent the contagion of true syphilis, a prostitute should be logically confined for two years in prison when she had once had syphilis, which was out of the question, and quite a *reductio ad absurdum* of the Acts. Finally, as to the curative effects of auto-inoculation, it was now well known that in most instances secondary eruptions tended to pass away spontaneously, so that these inoculations merely gave time for natural processes to run on.

February 16th, 1874.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. JABEZ HOGG read a paper on

HEMIOPIA SUPERVENING ON AN ATTACK OF PARTIAL PARALYSIS.

Mr. Hogg commenced by stating that hemiopia was a symptom of cerebral or functional derangement, and a term employed by ophthalmic surgeons to indicate partial blindness or half vision, loss of visual power, bilaterally, superiorly, or inferiorly. He went on to say that in a large number of cases portions of both eyes were affected, and objects were either wholly or partially blotted out, while in all, the visual field is considerably contracted. The power of forming visible groupings is suspended, and the patient obliged to make an unusual effort, for the time being, to recover the point of fixation. He reminded the Society that the image of this spot was situated on the foramen centrale, and that the integrity and perfection of this sensitive part of the retina always determined the acuteness of vision. There were, however, other portions of the nervous tissue of almost equal importance in seeing, and for securing acuity of indirect vision. Hemiopia, an indication or manifestation of derangement, is then a partial suspension or paralysis of nerve elements, due to pressure or to disease of one or other optic tract. Diseases of the inner coats of the eye, however, affect indirect vision in an irregular or circumscribed manner. In most cases of hemiopia there was just enough functional energy to keep up the nutrition of the optic discs.

In ordinary cases certain portions of the retina are insensible to the action of light. Mr. Hogg said Dr. Knapp believed hemiopia to be often associated with embolism and obstruction of the central branches of the retinal artery, his theory being that "when a primary branch of the central artery is obstructed, it results in superior or inferior hemiopia; but when a secondary branch only is obstructed, a sector-like defect of vision occurs; that portion of the optic papilla lying in the opposite direction to the defect in the

visual field becoming white and punctated, and partial atrophy of the nerve being likely to follow." The obstructed arteries undoubtedly become thinner, and after leaving the papilla are lost, while the veins remain unaffected. Grafe noticed associated with hemiopia an atrophic condition of the optic tract only. Mr. Hogg said that the decussation at the chiasma supplied nerve-fibres to the outer part of one eye and the inner part of the other, and thus explained why a pressure made over the optic tract of one side produced corresponding loss of sensibility in portions of both eyes, but it did not, he thought, so satisfactorily explain those horizontal and sector-like defects of vision or such a case as that placed on record by Dr. Knapp, and in which the visual defect had a central origin. He then briefly alluded to those cases of half vision traceable to a deficient or defective blood supply, to anæmia of the brain, and heart disease, and concluded by narrating the particulars of a case of hemiopia supervening on an attack of partial paralysis.

In July, 1872, Mr. Hogg was requested to see the wife of a medical man who was suffering from bilateral hemiopia. She stated that in the autumn of 1863, and again in May, 1866, she had suffered from slight paralysis, affecting the right arm and leg. Both attacks passed off but left her somewhat weak, and thus preventing her taking her usual exercise. She became very stout, but under a rigid diet and more exercise she became thinner and walked with more comfort.

In June, 1872, after some derangement of the stomach, the patient noticed a cloud hanging before her sight, and made several ineffectual attempts to brush it away. On the following day one half of every object was invisible. In July she complained of being unable to distinguish things standing on her left-hand side; the dimness of sight was so great that it required quite an effort to name near or distant objects, and the visual field was much contracted. She was hysterical and a good deal depressed about her condition, but in no other way was her health affected. The ophthalmoscope revealed an anæmic condition of fundus; half of each optic nerve was visibly paler than the other, the vessels being small and much diminished in size. Bark and ammonia with counter-irritation were tried for some days without material change in any of the symptoms, and then change of air was decided on.

In May, 1873, some improvement had taken place, for

when the patient stood 4 feet 8 inches from the mantelpiece she could see any object $3\frac{1}{2}$ inches to the left of one placed before her. At a distance of 7 feet 5 inches she could see the same object when moved to about 7 inches from the point of sight. She wrote: "At 150 yards from the house I see objects, as a tree, &c., to the left of a given point of sight more perfectly than I do at shorter distances. I conclude, therefore, that my distant vision has slightly improved."

On August 14th, 1873, the patient wrote: "I think my sight slightly improved, for on looking towards the tree, and directing my eyes to the top of it, I can see a child standing on the left hand side as well as the whole of the tree, but singularly enough I cannot see the child and tree if I make the trunk the point of sight. I am still taking the bromide of iron and strychnine."

January 7th, 1874, the patient having in the mean time removed to Herne Bay, wrote: "I am certainly better; my lateral vision is improving, although I have a very contracted field. I can see better if I make use of two pairs of spectacles; the deeper concaves you last recommended with my former pair." The lady having always been myopic this difficulty is probably on the increase, and associated with a slight degree of astigmatism. The patient having, however, improved in general health, the hemiplegia having entirely passed away, and the heart being perfectly sound, it is a question as to what the symptom hemiopia may be attributed. It appeared to Mr. Hogg to be associated with the partial paralysis as already pointed out. But did this arise from a growth within the cranium and pressure near the optic tract, which may hereafter develope itself into further loss of brain function? If so, the prognosis of the case must be unfavorable to the patient.

Dr. HUGHLINGS JACKSON thought the case related by Mr. Hogg was an interesting one. In that case there must have been two lesions, one for the hemiplegia, and another for the hemiopia. The speaker had seen several cases in which hemiopia had come on at the same time as hemiplegia, and here there was probably but one lesion. The hemiopia was such that the patient could not see to his paralysed side, the disease, causing these two intelligibly associated symptoms, would be on the side of the brain opposite the side of the body paralysed. A tailor was now under his observation; he has left hemiopia (field) and left hemiplegia; there is in the arm apparently little affection of motion, but there is very great defect of sensation; there is, indeed, defective sensation of the

left half of the body. One day he burnt his left hand with the nose of his tailoring iron; and he burnt it severely, because being unable to see to his left, and his left hand being insensitive, he had no knowledge of his mistake. Cases of this sort are the sensory analogues of the cases of hemiplegia, in which there is lateral deviation of the two eyes; in the former there is loss of power of vision to see towards the side paralysed, and in the latter loss of power to look to the side affected. In the latter, however, the lateral deviation of the eyes is a temporary symptom, yet it may be that there is not unfrequently a temporary hemiopia with hemiplegia. Right (field) hemiopia is more troublesome than left, as we read and write from left to right. Dr. Hughlings Jackson had discovered right hemiopia in several cases of affection of speech (partial aphasia); it then by a quasi-mechanical difficulty adds to the mental difficulty the patient has in writing. The cases of hemiopia with hemiplegia appeared to him to be the permanent analogues of certain cases of migraine described by Anstie, Latham, and Liveing. In some of these cases there is temporary hemiopia, with temporary defect of speech and temporary defect of sensation in the limbs. In no case of hemiopia that Dr. H. Jackson had seen was there any morbid ophthalmoscopic appearances; he had, however, had no opportunity of examining a case of temporary hemiopia. In one case of hemiopia complete blindness occurred, and there were the signs of simple atrophy.

Dr. COTTON exhibited a kettle for steaming the rooms of patients suffering from bronchitis and other lung affections.

February 23rd, 1874.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. MAUNDER exhibited a patient æt. 23, upon whom, ten years ago, he had performed

EXCISION OF ONE ELBOW-JOINT AND OF ONE ANKLE-JOINT.

He was led to show the case because excision of the ankle-joint is comparatively a rare operation, and Fellows would thus have an

opportunity of seeing what a useful limb had resulted. The lad had been for years accustomed to be on his feet in business for many hours daily, and he walked with a scarcely perceptible halt. The steps of the operation consisted chiefly in a longitudinal incision over the lower extremity of both tibia and fibula, with a transverse incision below on the inner side, providing that existing wounds cannot be utilised. The lower ends of these bones having been removed, the superior articulating surface of the astragalus can be removed either by dislocating the foot outwards, or, as in the present instance, by using the saw from before backwards. A wound on both sides of the leg favours a free discharge of secretions, which is very desirable. Another point of interest connected with this case is, that the first-born child of the patient had the corresponding lower extremity shorter than its fellow. This was discovered accidentally by the mother observing two folds of integument on the inner side of the left thigh, and one fold only on the right or shorter thigh. The child has always had good health, and walked when it was eleven months old. The shorter limb and the corresponding buttock are relatively smaller than those of the opposite side, but the child has, and always has had, perfect control over the limb. On measurement, the shortening, which is to the extent of an inch, is found to be due to a short femur, the legs being of equal length. The effect of the malformation is to make the child limp on walking, unless it wears a thickened boot. He looked upon the case as a coincidence, and not as cause and effect. It had never occurred to the mother during pregnancy that any deformity would exist in her then unborn infant. The upper extremities correspond.

Mr. HENRY LEE said he believed that the shortening of the limb in the child might be due to the mental effect produced on the mother by the deformity of the father, and he narrated the particulars of a case in which a lady who, having been greatly shocked by the sight of a clubfoot during the fourth month of pregnancy, had at the full period given birth to a child in whom there was a complete absence of malleoli. Mr. Lee then spoke of the various methods of excising the ankle-joint, an operation rarely performed.

Mr. MAUNDER having replied to some observations of Mr. Adams, remarked that with regard to the method of excising the ankle-joint, he did not attach much importance to that; it should

be done on general principles—that is to say, inflicting as little injury as possible, whilst details must be left to the judgment of the individual. As a rule, a longitudinal incision over the lower extremity of tibia and fibula, at the same time utilising any existing wound, will suffice; the malleoli being removed, a narrow, straight saw worked to and fro, and from behind forwards, will remove the superior articular surface of the astragalus.

Mr. DAVY said he did not believe in transmitted influence.

Dr. ALFRED CARPENTER, of Croydon, could not doubt that some mental shocks to the mother had an effect on the offspring, and he instanced the case of a woman, three months *enceinte*, who witnessed a ruffianly attack made on her husband, who received a severe scalp wound on the left parietal bone, and whose infant, at birth, had the bones of the left side of the head much flattened, and a large mark on the scalp in the exact position of the cicatrix on the father.

Dr. LEONARD SEDGWICK, in referring to this subject, said he had found corresponding malformations in plants, in which case, of course, maternal influence was out of the question.

The PRESIDENT called attention to the fact, that alterations in temperature during the hatching of chickens would lead to the formation of monstrosities, and suggested that this might have produced those abnormal conditions in the plants mentioned by the last speaker.

Mr. STILWELL, of Epsom, said that he was not altogether prepared to disbelieve the effect mental impressions had in producing abnormalities. Many years since, a farmer's wife under his care gave birth to a female child well-formed, except that there was a great want of development in the cervical vertebræ, and a lateral compression of the occipital bone. The child lived some years, but had not the slightest power to raise the head, nor was there any growth in the cervical vertebræ, or change in the state of the occiput. A travelling woman asked Mr. Stilwell if he was aware of the cause of this? She stated, that when calling one day, to sell tapes, &c., the gate fell to; and a fine young turkey's head was caught between the gate and gate post, and the bird fell dead. The farmer's wife, who was about three months pregnant, fainted, was much distressed, and remained ill for some days. Was this the cause?

Dr. CLEMENT GODSON quoted a remarkable case he had seen, in which a sudden shock to the nervous system of a pregnant woman

had appeared to produce a corresponding impression upon the development of the foetus. In this instance, when born, large patches of the skin on the back and chest of the child were found to be coarse, of a dark colour, and covered with thick brown hair, corresponding, according to the mother's account, to that portion of her body which, to her terror, had been some months before her confinement embraced by a monkey, which had escaped from an organ-grinder in the street.

Dr. FARQUHARSON read a paper on

SOME PECULIARITIES OF PNEUMONIA IN EARLY LIFE.

After some preliminary remarks, the author stated that the pure lobar pneumonia of children does not differ so much from that of adults as we might suppose, considering the very trivial causes which light up acute fever in early life. Although the beginning is more insidious, the course is much the same, the temperature seldom exceeding 105° , and defervescence taking place from the sixth to the seventh day. The pain, however, is often so decidedly situated in the abdomen as even to simulate peritonitis; the cough is more irritable, and the dyspnoea frequently out of all proportion to the extent of lung tissue involved, it being suggested that this may sometimes be of a nervous character, as in hysterical women. The most marked distinctive peculiarity, however, is the tendency of the inflammation to attack the upper lobes by preference, and even when it reigns elsewhere it almost invariably creeps insidiously upwards, without rise of temperature or other special symptom. Whether this peculiarity of site necessitated a lowering of type, as in the adult, the author has been unable to decide. Coming to the physical signs, it was observed that the true crepitant râle is seldom observed, that bronchial rasping is the first stethoscopic indication, and that the dulness on percussion is attended by a peculiarly well-marked sense of resistance. Towards the apex a well-marked tympanitic percussion note often intervened between the healthy sound and absolute dulness, and differs from the same symptom in the adult by reappearing during the stage of resolution. After various other points had been passed in review and a word said on prognosis, the author referred briefly to treatment, and dwelt specially on the value of poultices, in restricting the movements of the lungs, and giving rest to the affected tissues.

Dr. W. H. DAY congratulated Dr. Farquharson on his interesting and valuable contribution to the pathology of pneumonia in children. He said no disease was more variable in its extent and severity. The pulse and respiration bore no corresponding relation to each other. He had lately seen a case of acute pneumonia in a boy, *æt.* 10, where the lung rapidly passed into consolidation from base to apex, without cough or expectoration, the pulse reaching 140, and the respiration never exceeding 30 per minute. Not the faintest trace of breathing could be detected in the affected lung. The heart sounds were very audible throughout the left chest. There had been considerable abdominal pain, which was due to the extension of pleurisy on the left side. In some cases of this kind the abdominal symptoms have resembled, and been even mistaken for peritonitis. Dr. Day thought pneumonia was a disease that often recovered under rest and hygienic treatment alone, without any aid from drugs. No two cases were suited for the same treatment—there were always prominent points of difference in every case. Whatever plan was adopted, the constitutional treatment should be carefully kept in view, for the local condition was of secondary importance. He thought pneumonia of the apices of the lungs was generally observed in tubercular subjects.

Dr. CLEMENT GODSON drew attention to the frequency of the pain being referred to a distant part, which was apt to mislead in the absence of cough or pain in the chest; such a case had occurred to him lately in a boy suffering from commencing pneumonia, who had only complained of acute pain in the left hypochondrium.

Dr. MILNER FOTHERGILL said that, while admiring the paper as a whole, he would much have liked to have heard some further remarks on treatment from Dr. Farquharson. The treatment of disease in children was one of the divisions of practical medicine with which the Profession was really least familiar. Some avoided antimony unduly, while others used it freely—perhaps too freely. Children do not stand a depressing treatment well, and, on the other hand, it is often difficult to make the friends see the nearly impending necessity for a stimulating plan of treatment, by which threatening perils may be averted, or to overcome their fear of increasing the existing inflammation. Consequently the treatment of infantile disease had become little more than nominal. It was very desirable that some more definite ideas should exist as to the principles of treatment in diseases of children.

March 2nd, 1874.

S. O. HABERSHON, M.D., President, in the Chair.

Mr. FRANCIS MASON showed

FOUR POLYPI REMOVED AT ONE OPERATION FROM
THE NOSTRIL OF A BOY, *ÆT.* 12.

The largest was horseshoe-shaped, measuring $2 \times 1\frac{1}{2}$ inches; the next in size was 2 inches long and 1 inch wide, and resembled a large slug. Both these were removed by evulsion with the ordinary polypus forceps, through the fauces and mouth. The remaining tumours were flattened out, elongated, and measured nearly 2 inches. They lay in the cavity of the nostril, and could be seen from the front, and were taken away with the forceps through the anterior nares. The pedicle of each polypus was extremely delicate. Mr. Mason spoke of the facility with which the operation was performed, and thought there was much less danger in adopting this method in removing polypi passing into the pharynx than is generally supposed. The application of a ligature to such tumours was a troublesome proceeding, and was really necessary in but few cases. He believed that severe hæmorrhage rarely accompanied the removal of the polypus; the bleeding was in most cases due to the attempts made by the operator to clear the nostril completely of the morbid growth, in doing which, the mucous membrane was unavoidably injured. The tumours had existed as long as the boy could remember. There was but little hæmorrhage in this case, which was no doubt due to the slender attachments of the growth.

Mr. DE MÉRIC referred to the use of "Hilton's snare" in these cases, and spoke of the practice of slitting up the velum, and the necessity in some cases of even removing the superior maxillary bone, in order to enable the operator to reach the base of the tumour.

Dr. PROSSER JAMES concurred in the opinion that there was little or no danger in removing polypi of this kind when the attachment was not broad; for cases thus manageable he deprecated the

more grave operations mentioned by Mr. de Méric. That was only to be resorted to in very different cases, where neither ligature, forceps, nor *écraseur* could be applied. He was surprised to hear no mention made of the rhinoscope. Without ignoring the *tactus eruditus*, he thought it less certain than vision, and by the aid of a mirror, a diagnosis could be formed at a much earlier period. The rhinoscope would enable the observer to see a polypus when it was very small, and guided by this instrument we could apply solid or fluid substances to the root of the pedicle after evulsions. By these methods we might sometimes supersede the necessity for operation when the polypi had been detected in an incipient stage.

Mr. HENRY SMITH showed a very fine specimen of an

ENCHONDROMATOUS TESTICLE.

At the operation the cord had been clamped and the actual cautery applied. The patient progressed favorably till the eighth day, when he complained of pain in his side. He did not have any shivering, but obstinate vomiting set in, and he died. At the autopsy the wound looked fairly healthy; there was no peritonitis. The diaphragmatic pleura was studded with lymph.

Messrs. de Méric, Bell, and Hainworth took part in the discussion which followed.

Mr. ROYES BELL then related some cases which had been successfully treated with the aspirator.

Mr. DURHAM showed some foreign bodies which he had removed from the urethra.

Mr. HENRY SMITH mentioned the particulars of a case in which he had removed a piece of tobacco-pipe from the bladder by lithotrity, and a few months afterwards he was called on to extract a small buttonhole flower tube with a piece of string attached from the urethra of the same patient (a young man).

Mr. CROFT spoke of a new instrument he had designed for the purpose of removing foreign bodies from the urethra, the chief peculiarity of which was that the blades of the forceps were fenestrated and opened parallel to each other.

March 9th, 1874.

The 101st Anniversary Dinner took place at St. James's Hall. The President, Dr. Habershon, presided, and upwards of 90 Fellows and their friends dined. The Fothergillian gold medal was presented to Dr. J. K. Spender, of Bath, and the Society's silver medal to Dr. Alfred Wiltshire, the outgoing secretary, for special services rendered to the Society.

March 16th, 1874.

VICTOR DE MÉRIC, Esq., President, in the Chair.

The thanks of the Society having been warmly accorded to Dr. Habershon, the retiring President, and also to the Officers and Council—

The PRESIDENT, Mr. de Méric, said, on taking the Chair, that while praising the energy that had been displayed by his predecessor, Dr. Habershon, and Mr. Thomas Bryant, who was chiefly instrumental in taking these premises and enabling the Society to meet in such a handsome and comfortable room, he still would call the attention of, especially the younger, Fellows to the amalgamation of the Medical Society with the Westminster Medical Society, which took place twenty-two years ago, which resulted in the formation of the present influential and powerful body, over which he had now the honour to preside, and he trusted he should have the assistance of the Fellows in keeping up the tone and interest of these meetings. This Society had been characterised for the freedom of its discussions, and this character he wished to maintain. He did not ask for any great eloquence from the speakers, but he would wish the subjects brought forward to be fully and carefully discussed in their practical bearing. On the Continent he had noticed a custom in the societies of bringing forward patients suffering from obscure diseases or injuries, and in the way of a general consultation, of obtaining opinions from the members. This

custom had been productive of much good, and he would very much like to see it followed in the Medical Society of London.

Dr. Dowse exhibited an unusually

LARGE BASILAR ARTERY,

removed from a patient, æt. 56, who was admitted into the Highgate Infirmary, suffering from right and pseudo-left hemiplegia. At the post-mortem there was found to be chronic thickening of the membrane covering the hemispheres, with sub-arachnoid and serous effusion and extravasated blood; the substance of the hemispheres presented numerous vascular puncta, and the lateral ventricles contained some fluid, but no marked degenerative change was apparent here. At the base both temporo-sphenoid lobes were somewhat softened, but the foci of disintegration were manifested upon exposing the corpora striata. At these parts slight hæmorrhages had taken place, and the change in the brain structure had been followed with progressive paralysis. The arteries at the base were markedly atheromatous, and this state appeared throughout the endo-cerebral circulation. The basilar, instead of being about an inch long and the size of a crow-quill, was two inches long and as large as a common iliac; it rested on the pons rather in a diagonal, than a straight, direction. Dr. Dowse would remark that had the artery been of normal length it might be regarded merely as an aneurismal dilatation of the vessel, but the unusual length led him to the conclusion that it was a naturally formed artery although much out of proportion. He had examined a very large number of brains, but never met anything like it before, neither has he ever found such a condition recorded. Dr. Dowse also showed an elbow-joint with an unreduced dislocation backwards of both bones of thirty years' standing, the subject, a woman, having for the last few years a very useful arm.

Mr. THOMAS BRYANT thought the specimen extremely interesting, and suggested that Dr. Dowse should allow a section of the bones to be made, and to show the preparation again.

This Dr. Dowse agreed to do.

Dr. FOTHERGILL then read a paper on

SOME POINTS IN THE TREATMENT OF DISEASES OF CHILDREN,

in which he pointed out that, owing to the impressionability of the

nervous system in children, depressants were only required for a brief time in the treatment of acute disease; also that the plan of giving children stimulants freely and habitually when in health was bad, but that in acute exhausting disease they might be used with benefit, especially in connection with easily assimilable food. Much mischief often arose from unfounded fears on the mother's part as to adding to the inflammation by such measures, and the consequence was that many sick children perished from lack of strength. He then alluded to the common condition of a ravenous appetite coexistent with steadily progressive wasting; the more the child eats, the quicker it perishes of inanition, in consequence of its inability to digest food: restriction in the amount of food given often led to recovery. Diarrhœa in children was often a natural means of removing masses of indigestible or irritant material, and the plan of attempting to check such diarrhœa by astringents frequently led to a condition of enteritis. The treatment was to clear away the offending matter by a dose of rhubarb or castor oil, and then to change the dietary. In many children who were suckled beyond the weaning point, or when the food was insufficient, there exists a form of diarrhœa with green stools which was curable by proper nutrition. Dr. Fothergill also thought that the anti-syphilitic treatment of disease in children who were congenitally syphilitic was confined too much to these manifestations, which were associated with the pre-dental period of a child's existence. Experience had taught him that there were conditions of anæmia where the addition of mercury to the hæmatics administered was very beneficial up to the time of the second dentition, if indeed that or any other limit could be assigned. The diathetic element required its special treatment as much in congenital syphilis, as did the cachexia of acquired syphilis, for successful practice. Finally, he drew attention to the conditions of excessive acidity of the secretions of strumous or scrofulous children, to the sour perspiration, the destruction of the teeth, and the uric acid in the urine. This might be due to imperfect oxidation or imperfect nutrition and assimilation, or both combined. As to the first, we are all familiar with the excellent effects of fresh air, especially at the sea coast, upon strumous children, and Sugol had found such children much improved at harvest time when out of doors gleaning. Alkalies, especially potash, had been found useful by Brandish, Brodie, and others, as removing or neutralising the excessive acidity. But, in

addition to this, rectification and improvement of the nutritive and digestive processes were necessary. It was possible that many of the peptones never became tissue, but were directly oxidised into urine products, and also that more sugar was split up into lactic acid than the system could oxidise, and so it accumulated in the body.

The PRESIDENT thanked Dr. Fothergill, and would advise authors to conclude by putting forth such resolutions as could be deduced from their papers. This would greatly assist in the discussion, and enable the points to be carried out.

Dr. DAY considered that stimulants were injurious to children in health, and were rarely required in disease. In many forms of enteric fever, bronchitis, diphtheria, &c., the value of stimulants could not be doubted, yet he believed that most children under ten years of age would struggle through the usual complaints of childhood without them if well supplied with milk and other nutritious food. He thought that an excessive appetite in children was often accompanied by feeble digestion and imperfect chylication. It was not uncommon to see children with enormous appetites wasting away at the same time. The tongue in these cases is often furred at the back, and there are patches of superficial ulceration at the tip and sides. Such cases may end in phthisis and mesenteric disease, unless the diet be strictly attended to.

Dr. BRUNTON mentioned the number of children who suffer from eczema, the result of the practice of giving their children beer, which prevails among the lower orders. He had himself found brandy given with milk very useful, not so much as a stimulant as to aid in the digestion of the milk. He had made a great many thermometric observations on children, and now saw, without any anxiety, high degrees of temperature reached.

Dr. HEYWOOD SMITH spoke of the value of wine given in large quantities to children suffering with bad sore throats. In some instances he had given as much as half a bottle a day.

Dr. SANSOM pointed out the large proportion of the diseases from which children suffer as having an undercurrent of syphilis, and which only do well when treated with mercury in some form or other.

Dr. R. J. LEE mentioned the frequent occurrence in children of smart feverish attacks apparently without cause, and which generally came on at night. He thought they were due in part to some

derangement of the absorbent system, which was greatly developed in children. He would like to know what pathological conditions existed in these cases.

Dr. THOROWGOOD would mention that the *raison d'être* for stimulants being beneficial to children in certain cases was their effect on their capillary circulation, and that in capillary bronchitis alcohol was pre-eminently useful.

March 23rd, 1874.

VICTOR DE MÉRIC, Esq., President, in the Chair.

Mr. THOMAS BRYANT read the notes of a case of a

FOREIGN BODY DISCHARGED THROUGH THE ABDOMINAL PARIETES,

recorded by T. B. Dyer, Esq., M.D. A woman, æt. 56, a patient in Colney Hatch Ayslum, suffering from melancholia, and who on two occasions attempted suicide, told the nurse that during the previous night, March 10th, 1873, she had twisted off part of the iron handle of the night-stool and had swallowed it. The handle was found to be broken and part of it had disappeared. She was kept under special observation for some days, and as her bodily and mental symptoms remained unchanged, it was hoped that she had not swallowed it after all. However, while she was being bathed, on May 15th, a tumour, the size of half a small orange, was observed on the right and upper part of the umbilicus; it was hard and shining and of a dull red colour; no fluctuation could be felt. She was now kept in bed for further observation, and a poultice was applied to the tumour. On the 19th of May a quantity of pus was discharged, having a *decidedly fæcal odour*; her bowels were opened daily, and she complained of very little pain. Pulse 70; temp. 100°; appetite very good. The discharge continued freely for two days, and on the removal of the poultice, on the 21st May, a black substance was seen protruding from the orifice, which was easily withdrawn with a pair of forceps. This proved to be a piece

of thick iron wire answering to the portion of the handle said to have been swallowed in March. The abscess was kept poulticed, and Tr. Opii \mathfrak{m}_{xxx} given twice a day. The discharge continued until the 23rd May, when it ceased, and the patient then complained of more pain around the umbilicus, and sometimes at the rectum and in the bowels. On the 24th a large quantity of mucus was discharged from the bowels, and what appeared to be shreds of membrane; a dose of castor oil was given, and she passed more mucus and fæces; the swelling then gradually subsided and she recovered her health; and now, November 10th, a small scar only shows where the abscess was. Her mental symptoms have altered lately; from being low spirited and melancholy, she is rather excited and maniacal. [Piece of wire shown to the Fellows.] Mr. Bryant called attention to the remarkably local character of the inflammation; the pus having a distinctly fæcal odour, the opening in the bowel must have been some distance down the small intestine for it to have acquired this smell. He also mentioned the curious absence of all symptoms until suppuration took place. He also spoke of a case, reported in the 'Transactions of the Medical Society of Manchester,' where a woman, æt. 26, swallowed a dessert-knife, the metal of which measured six and a half inches. Eight weeks afterwards a globulous swelling appeared on the right side nearly on a level with the umbilicus, and the sharp edge of the foreign body was distinctly felt. After a few days the blade of the knife protruded, and was removed by a trocar. The ivory handle had been entirely digested, and the extremity of the blade rendered thin by the action of the gastric juice. In this case also the patient made a good recovery.

Mr. BRUDENELL CARTER attributed the fortunate termination of the first case to the remarkable fortitude and tolerance of pain generally shown by insane people.

Dr. COCKLE then related a case of

LABIAL CARBUNCLE, FATAL FROM PYÆMIA.

Without feeling quite sure that the term really defined the actual pathology of such cases, it is adhered to in conformity with current usage. For some time confounded with cases of malignant pustule they appear to have been accurately differentiated, at least in this country by Mr. Henry Ludlaw in 1852. But whatever their pathology, such cases are far from common, and we regard them

as being ultimately connected with some antecedent constitutional dyscrasia.

Mr. C—, æt. 38, well formed, and capable of sustained exertion, laboured under a weak circulation and unusual coldness of the surface; complexion of an unhealthy sallow tint. Eight years ago he had a severe attack of hæmoptysis followed by signs of serious disease of the upper portion of the right lung. From this condition, however, he recovered, and about four years ago, what appeared to be an ordinary boil appeared at the back of the neck, and this remained an open sore for some weeks in spite of treatment. Both before and after this last affection he complained of giddiness and numbness of the lower extremities, probably caused by weakness of the circulation, as he was invariably relieved by the liberal use of stimulants. On the 16th of February last a pustule, slightly discharging, was observed upon the left upper lip, below the moustache; it was unattended with pain; there was merely a sense of discomfort from the swelling. He had been overworking himself, but his appetite was fairly good, nor was there any constitutional disturbance.

On the 17th the lip remained in the same state, with a slight increase in the discharge.

19th.—Pain in chest, side, and back, apparently muscular.

20th.—The patient was delirious; temp. 104° ; pulse 120; swelling of lip greatly increased, and also a hard white swelling extended up to the left eye; upper and lower eyelids closed. A second pustule now formed above and near the first; the swelling invaded the opposite cheek, and the features were no longer recognisable. Pains in the chest ceased, and death took place on the 22nd.

No albumen or sugar was detected.

For special reasons no post-mortem examination could be obtained. It may be a matter of question whether death took place from the extension of the inflammation to the cerebral sinuses, or from blood infection, or from a combination of both. As against the former view, headache and exophthalmia were wanting, while in favour of pyæmia there existed shiverings, followed by perspirations, semi-ictine tint of complexion, intense pain in chest, side, and back, marked elevation of temperature, rapid failure of circulation, with sudden and fatal prostration. The peculiar odour of the breath often present in pyæmia was not distinctly marked; and possibly was

masked by the condition of the lip. Although such cases may have many constitutional symptoms in common with malignant pustule, and thereby, at times, confuse the diagnosis, they seem, on the authority of the best observers, more particularly Guipon and Reverdin, to be sharply demarcated by the local presence of some amount of true purulent formation. This clearly recognised, at once removes the case from the category of malignant pustule.

Mr. BRYANT directed attention to the extension of the mischief to the cerebral sinuses in this class of disease, and the usually fatal results which attended this complication.

Dr. SYMES THOMPSON asked Dr. Cockle's opinion of the difference between genuine carbuncle and malignant pustule.

Dr. FAYRER had seen many cases of carbuncle, and had recorded one or two very similar to that related by Dr. Cockle; but whether on the lip or other part of the face, the nape of the neck, the shoulder or back, they are essentially the same disease, significant of a broken-down constitution and a depraved condition of the blood-elaborating apparatus. Though of great local importance, they are eminently significant of constitutional disorder, and in India, at least, generally accompanied by sugar in the urine (diabetes). Whether large or small their pathology is the same; they are the expression of a general state, whether it be of broken-down constitution accompanied by diabetes or other evidence thereof, or whether an ordinary boil, which is the faintest expression of something more than that of a mere local origin. The local mischief in both, frequently, if not always, begins with the death of a small portion of areolar tissue, from capillary embolism, it may be, and around this, suppuration is set up for the purpose of throwing off the dead tissue. The same process, or something like it, takes place in carbuncle; but here the death is prone to spread, and in those cases where sugar is present, carbuncle is very frequently, though not always, fatal; where it is absent or not excessive, and the general health otherwise good, recovery even from large carbuncle is not infrequent. Death, especially in cases referred to as carbuncle of the face, occurred from pyæmia, ichoræmia or toxæmia, whatever you like to call it, from infection of the blood at any rate, though in some cases it was due to other causes, as from exhaustion from the carbuncle or other concurrent disease. But the death that results from this so-called pyæmia does not always imply a collection of abscesses either visceral or subcutaneous; it is rather

due to the presence of a poison which frequently kills before there has been time for suppuration, and which produces necrosis of patches of the lungs, liver, and other viscera, or exudation of puriform lymph into the cavities. If in these cases death does not take place early, suppuration will sooner or later occur around these portions of the dead tissue for the purpose of getting rid of them. Manifestly, such cases must be fatal. No doubt some are the so-called local abscesses; and it is fortunate for him in whom the disease manifests itself if it does so in the areolar tissue *outside* instead of *in* the viscera within the cavities. But death also frequently occurs from rapid obstruction of the pulmonary circulation by the formation of firm adherent fibrinous coagula in the right side of the heart, or in some part of the pulmonic circulation, this dangerous condition being likely to occur in the blood of persons who have been the subject of functional if not structural derangement of the liver, and especially in malarious climates.

The PRESIDENT inquired respecting the treatment adopted.

Dr. COCKLE, in reply, said the rich experience of Dr. Fayrer showed not only how frequently cases of carbuncle occur in tropical climates, and also how at times pyæmia results. But in the true carbuncle class we ordinarily find that the mischief is at first mostly subcutaneous, and the sloughing parts crop up, as it were, from below; but in the case recorded the pustule appeared to be almost the initial phenomenon; the hardness and swelling were, if not actually successive, at least, simultaneous. Again, we must not forget the sudden increase after two or three days of the swelling of the lip, coincident with the supervention of pyæmic phenomena. Another important fact to be borne in mind is, that a few years since English and German surgeons, and later still physicians, well conversant with genuine carbuncle, regarded cases analogous with that which we have recorded as cases of malignant pustule. In this point of pathology they were, however, probably in error, inasmuch as the observation of the French pathologists most experienced in the history of malignant pustule, most unhesitatingly affirm that the local presence of pus is exclusive of the latter affection, and this may be some answer to the inquiry of Dr. Symes Thompson. So that looking to all these facts we consider that there are residua in the history of these cases which demand further elucidation.* The President had pertinently inquired respecting the treatment

adopted in our case, and it was certainly an omission not to have more directly referred to it. In the early stage, bark, ammonia, and wine; locally, warm poppy fomentations were applied. Incisions were not resorted to, not alone from fear in such a subject of the possible hæmorrhage, but from a disbelief in their efficiency under the circumstances. The discharge of pus was comparatively free. Later yet, that is on the supervention of signs of blood infection, large doses of tinct. sesquichloride of iron, with a large quantity of stimulants, were given without the slightest benefit.

Dr. DOWSE then exhibited an elbow-joint which had been the seat of injury some thirty years ago. It was removed (post-mortem) from a woman, æt. 64, who was admitted into the Central London Sick Asylum, at Highgate, suffering from post-pharyngeal abscess. His attention was not directed to the elbow until about a week before her decease, when she fell down in a fit of apoplexy, from which she died. After the fall he examined the joint, and was somewhat at a loss to determine its exact condition. The arm could not be extended, but there was flexion, supination, and pronation. He was informed by her relatives that she had met with the injury thirty years back. On examining the joint after its removal, it was found to be unique and exceptional. The radius and ulna were both dislocated backwards, but in addition to this there was an oblique fracture of the internal condyle of the humerus, which had become ankylosed, and the fractional extremities were converted into a false joint. The neck of the radius, anteriorly, and for some little distance down the shaft, the bone substance, was eburnated, and played on the outer condyle of the humerus, forming also an artificial articulation.

The HON. SECRETARY (Mr. Woodhouse Braine) then read a description of a new instrument which had been invented by Dr. Tuchman, the object of which was to close either ureter, and allow the urine secreted from the other kidney to be collected and tested.

It was resolved that the instrument should be tested and reported on at a future meeting.

March 30th, 1874.

VICTOR DE MÉRIC, Esq., President, in the Chair.

Mr. WOODHOUSE BRAINE exhibited a new instrument he had invented for the better supply of nitrous oxide during administration. The iron bottle containing the gas, being placed in a stand, rotated, and was easily turned by the foot. The quantity required could be obtained and regulated by this means without the necessity of the administrator's hand being away from the patient's pulse while the inhalation was proceeding. Another advantage it possessed was, the ease with which the gas could be turned off and on. It was to be obtained at Messrs. Coxeter's, Grafton Street East.

Mr. CLOVER praised the instrument, and remarked that he had been in the habit of enclosing the neck of his iron bottle in a small tin cylinder, made circular, thus making a sort of warm bath to surround it, and so preventing the freezing of the water, which sometimes caused annoyance by setting fast the valve of the bottle.

The PRESIDENT asked Mr. Braine whether the blue appearance and apparently asphyxiated condition of the patients did not cause some uneasiness; he also wished to know the length of time the anæsthetic effect could be kept up, and whether any fatal case from its use had been recorded.

Mr. B. Carter, Mr. Sewell, and Dr. Cumberbatch having spoken,

Mr. BRAINE replied, and said in answer that he did not consider from experiments he had made on himself that the condition of anæsthesia from nitrous oxide was one of asphyxia, and that if the effect of the gas was carefully watched, unremittingly, during administration, he believed it was the safest anæsthetic yet discovered. One death had taken place from its use; but in this case the dentist was giving the gas himself singlehanded, a practice which Mr. Braine very strongly condemned. He had kept up the anæsthesia in a case of a patient of Mr. Adams for thirty-five minutes, allowing the subject to become conscious twice during that time, but for long operations like this he greatly preferred giving gas or methylene ether first, and then following up with pure ether.

Dr. BRUNTON read a paper

ON THE THERAPEUTIC USE OF ACONITE.

He showed that the only aconite that could be relied upon was the aconitum Napellus, which had been selected by Baron Antonius Störck as the true drug: "eam a reliquis separare quæ vera est." Dr. Brunton said that aconite as used in practice had fallen into an undeserved oblivion, and he quoted from Dr. Garrod's 'Materia Medica':—It (aconite) is at the present time not very often employed, or only by a very limited number of practitioners," p. 163. After detailing the history of aconite and its preparations, he said that the best and least dangerous was the tincture of the British Pharmacopœia. He brought forward this paper as an expansion of one of Dr. Fothergill's corollaries from his paper recently read to the Society, on "The Depressants of the Circulation." He (Dr. Brunton) showed briefly the action of aconite in poisonous and in medicinal doses, that it acted as a powerful depressant and sedative to the heart and circulation, and that when death occurs it is frequently as in hæmorrhage. He quoted Dr. Fleming, who stated that patients who had taken too large a dose but recovered, felt as if dying from excessive loss of blood. Upon this power of the drug was founded the therapeutic value. When administered in medicinal doses, the general result was similar to bloodletting, but in a somewhat different way. Bloodletting weakens the force of the heart by diminishing pressure on the vessels, while aconite diminishes pressure on the vessels, by weakening the force of the heart.

The action of aconite was:

1. To lower the heart's action.
2. To lower the lungs' action.
3. To lower the temperature of the body.
4. To produce free transpiration.
5. To produce sleep.
6. To starve a too vascular area.

In short, aconite was our best substitute for general and local bloodletting; that it was our best agent just in those cases where formerly the lancet or leeches would have been used.

He also showed that the power which had been assigned to this drug by Störck (in 1761), and which had since been denied, was quite correct, *i. e.*, its deobstruent power; and in support he quoted

a few of many cases he had in practice, in which sole reliance was put on aconite for cure of enlarged glands, cervical, mammary, tonsillar, chronic hepatic enlargement, &c., and with complete satisfaction in result.

He read notes of cases of acute disease where aconite was used, such as pulmonary congestion, catarrhal fever, pneumonia in its early stage, laryngitis, bronchial catarrh, acute nephritis, acute general eczema, and the like. He also detailed his observations on the temperature of the body during the action of aconite, and showed how rapidly and steadily it was lowered. Details were given of local inflammation, as orchitis and inflammation of the knee-joint treated by aconite. Its use in the early stage of eruptive fevers was mentioned, and he found it cut short attacks of parotitis, and was decidedly most beneficial in acute ophthalmia. After detailing many illustrative cases, notes of which were taken during the past five years, and calling the Society's attention to the mode of administering aconite, viz., in small and often repeated doses, from one minim to quarter of a minim every fifteen minutes for the first hour or two hours, according as the circumstances of the case might demand, and one minim every hour after, the action of the drug thereby was kept up without producing poisonous symptoms. Of course, the aconite was to be omitted as soon as it had done its duty, and other suitable treatment adopted.

He gave the following as his conclusions after very extensive use of the drug in private practice, extending over a period of twenty-five years :

1. The best preparation is the British tincture.
2. It is best administered in oft-repeated small doses ; it is nearly tasteless.
3. Its use can be continued for weeks, as it is not cumulative.
4. It is our best antiphlogistic drug.
5. It is diaphoretic and diuretic, "*nec æger hoc sudore debilitatus est.*"
6. If it does not remove the products of inflammation when those are formed by its control, it prevents their formation, and so saves the tissue from further injury, and prevents tissue change.
7. It is most decidedly deobstruent.
8. It has the advantage that it does not leave that excessive weakness which follows ordinarily the diaphoresis produced by other drugs, such as antimony. "*Sub fine tamen æger copiosissimo*

sudore maduit vires inde diminutiæ non sunt.” “Appetitus bonus est et vires integræ.”

“Quo sæpius aconitum ægris exhibeo, eo majorem semper in hac planta virtutem es efficaciam admiror.”

Dr. PROSSER JAMES has used this drug for more than fifteen years, and published, in 1860, many of the operations Dr. Brunton had just read. He spoke very highly of the drug, and especially of the good effect it had when given in lozenges in attacks of tonsillitis. When toxicological symptoms appear, he advised, not the diminution of the drug, but its complete discontinuance for the time.

Dr. ROUTH said, he had read a paper to this Society sixteen years ago, and had then mentioned this particular way of giving aconite. He had found the action of the drug cumulative; in fact, as cumulative as digitalis; and he had seen children blanched and rendered almost pulseless at the end of twelve hours, even with doses of one twelfth drop of the tincture, made with the root. He then related the case of a young woman who for some neuralgic affection was rubbed with ointment containing aconite, and who for three days suffered from tonic spasm of the whole body. The mother of this woman who rubbed on the ointment unfortunately used her right hand, one of the fingers of which had a slight sore on it from the prick of a pin. The ointment appeared to have been absorbed at this spot, and persistent paralysis of the arm followed.

Mr. JABEZ HOGG said, he had known this drug to have been in use for twenty-five years in the Ophthalmic Hospital, and had never seen any bad effect follow its administration; it was usually given in five-drop doses every three hours.

Dr. FOTHERGILL said that the cases related by Dr. Brunton illustrated very conclusively the action of aconite as a vascular depressant; its action is to retard the contraction of the heart, at the same time diminishing its energy, and so to produce a marked effect upon the movement of the blood current, and through it again upon the chemical interchanges, and the production of heat. All are familiar with the low temperature of advanced heart disease; but this was not all its action. It affects the peripheral vessels, especially those of the skin, and so leads to a large bloodflow through the cooling cutaneous area, and by this more heat is lost. By the two actions combined the temperature of the body is distinctly reduced. He also thought that there was much in favour of the

plan advocated by Drs. Ringer and Brunton of the administration of small doses at short intervals, by which means a steadier continuous impression was kept up than was possible by the use of larger doses at longer intervals.

Dr. BURNES believed that the action of the medicine was on the sympathetic system, and then on the vascular. Large doses produced changes of the nervous centres, and he was decidedly in favour of small doses.

Dr. FAYREER said that the English tinct. acon. Nap. was the one generally used in India. The aconite ferox is the celebrated Visch or poison used there.

Dr. Broadbent, Dr. Heywood Smith, Mr. Hemming, and Mr. Brown also joined in the discussion.

Dr. BRUNTON, in reply, said that his observations were made quite independently of others, and were confirmed by them. He thanked the meeting.

April 13th, 1874.

VICTOR DE MÉRIC, Esq., President, in the Chair.

Professor ERASMUS WILSON, F.R.S., exhibited a specimen of

GURJUN OIL OR BALSAM;

and he stated that this material, which was also called "wood oil," was an oleo-resin obtained from several species of the *Dipterocarpus*, an immense tree growing on the Malayan Coast of the Bay of Bengal, where it was so common as to be used instead of paint for houses and ships. About twenty years ago this oil was introduced into England as a substitute for Copaiba balsam, and was reported to have some medical properties. Opinion was, however, divided on this point, and the Gurjun oil did not succeed in securing a place in the Pharmacopœia. In March, 1873, Dr. Dougall, of the Indian Medical Service, took charge of the convict establishment of the Andaman Islands, where he found twenty-four of the prisoners suffering from leprosy. He was deeply impressed with the misery of these poor people, and realising the impracticability of availing himself of all known methods of treatment, he hit upon the idea of

trying the Gurjun oil, both as an internal and external remedy, and determined upon giving it a six months' trial. He closed the experiment in November by a report, which was kindly placed in Mr. Wilson's hands by Sir Ranald Martin, and used in his lectures before the College of Surgeons. Dr. Dougall's method was to have the patients washed thoroughly in a neighbouring stream, using dry earth instead of soap. They were then made to rub themselves for two hours with a liniment composed of Gurjun oil and lime water, one part to three, and to swallow ʒij of the balsam also combined with lime water. After this they had their breakfast, and were set to any work they were capable of doing. In the evening the same process was repeated, except the washing. The effects of this treatment at the end of six months were marvellous. Neuralgic pains were allayed; sensibility was restored to the anæsthetic skin, tubercles subsided, and ulcers healed. Dr. Dougall was astonished with the energy of these formerly helpless ones. Mr Erasmus Wilson remarked that he had used a liniment composed of equal parts of the Gurjun oil and lime water in cases of painful eczema, in lupus, and in cancer, with very encouraging results, and stated that Mr. Hancock had applied it in a case of cancer of the skin with the effect of dispersing tubercles, and healing ulcerations; but its most useful property was that of relieving pain. A lady, in constant pain from cancer of the integument, who had been unable to sleep without narcotics for weeks, was relieved of all suffering and enabled to sleep by means of this liniment. Mr. Wilson suggested that this very simple remedy deserved a trial at the hands of the profession, and believed that it would be found a valuable agent of cure in many affections when the skin was painfully attacked. Mr. Wilson exhibited photographs of Dr. Dougall's patients before and after the treatment, and also capsules of the oil for internal treatment, which could be obtained at the principal chemists.

Dr. FAYRER stated that the Gurjun oil was an old remedy for various complaints, but he heard of its use for the first time in treating leprosy. The tree belonged to the Himalayan Flora, and was abundant on the Eastern Coast and in the Andaman Islands. He had found the oil useful in dysentery, in genito-urinary affections, and in healing up old ulcers. Though careful about accepting accounts of cures in India, where all drugs are over-vaunted, he could not resist the evidence of Dr Dougall, to whose careful investigation of the drug he paid a high tribute. He thought,

perhaps, the improvement in the health of the patients was due to the constant and careful cleansing, and more to the internal rather than the external use of the drug.

In reply to Dr. ROGERS,

Mr. WILSON said he had procured his first specimen from Messrs. Allen and Hanbury. Those shown were from Messrs. Bell and Co.

Mr. FRANCIS MASON exhibited a man, æt. 27, who had been under his observation at St. Thomas's Hospital with a

SYPHILITIC INFECTING SORE ON THE MIDDLE OF THE FRONT OF THE RIGHT THIGH.

It had existed for one month, commencing in an abrasion of which little notice had been taken. The patient stated that he had had intercourse two months previously, but since then had not placed himself in the position of getting a sore of any kind. At his first visit, on 19th March, Mr. Mason drew attention to the characteristic appearance and the complete history of the sore. The man was told to watch for any spots that might appear. A water-dressing was ordered and "placebo" medicine. In a week he returned to the hospital with a well-marked rubeoloid eruption over the abdomen. There was no sore on any other part of the body, and Mr. Mason concluded that the case was one of true syphilitic infection or indurated sore, followed, as such cases usually are, by constitutional symptoms. The patient was now taking the perchloride of mercury in $\frac{1}{12}$ -grain doses.

Mr. HENRY LEE said, the case required a clear antecedent history, and he remarked that as far as the sore itself was concerned it might be a secondary one, for he agreed with Ricord that in appearance it was impossible to distinguish a secondary from a primary sore. He thought that if Mr. Mason went more fully into the case some history of a primary infection might be elicited.

Mr. ACTON considered it might be a primary sore arising from the infection of an abraded surface. This often took place where a finger has been scratched. In this case the thigh had been scratched.

The PRESIDENT asked Mr. Mason whether, to make matters certain, he had inoculated the patient; and drawing attention to the different opinions of Mr. Acton and Mr. Lee, inclined to the view that the sore was primary.

Mr. HENRY LEE interposed that he did not say the sore was

secondary, but that the history of the case was wanting to show that it was not so.

Mr. GAY observed that the early occurrence of the skin eruption pointed to the sore being primary.

Mr. MASON briefly replied, and brought forward a man, *æt.* 48, who had three varieties of hernia—umbilical, femoral, and oblique-inguinal. He wore trusses, and only complained of a dragging sensation in the abdomen.

Mr. KEENE stated that he had given notice of a case of death resulting from the administration of the bichloride of methylene, but he had submitted a specimen of the anæsthetic used to Dr. Richardson, who had informed him that it was chloroform, and did not contain a particle of bichloride of methylene. He would therefore change the title of his paper to

DEATH FROM CHLOROFORM.

A woman, *æt.* 50, was admitted into the Central London Ophthalmic Hospital, under Mr. Wilkinson's care, for double glaucoma. On the same day after the administration of what was believed to be methylene bichloride, iridectomy was performed on the right eye, followed by considerable improvement. A week later it was intended to operate on the left eye. The anæsthetic was administered from the same bottle as before. The patient was nervous and timid, and held her breath at first. After a little encouragement and allowing her to become accustomed to the anæsthetic without forcing, she breathed more freely, and 60 minims were added to the 40 already given in the inhaler. In a short time she stiffened herself, drew back her head and remained for a few seconds in a state of general rigidity. The breathing became stertorous, hurried, and uneasy, and the inhaler was removed, the respiration being carefully watched for half a minute, during which time she endeavoured to eject saliva. She drew a deep inspiration, and ceased to breathe. The pulse stopped, and in spite of the use of the wet towel, of ammonia to the nostrils, and artificial respiration on Sylvester's method, no reaction, with the exception of one or two efforts at breathing, took place. The treatment was kept up for ten minutes, but the woman was quite dead. There was nothing in her appearance before the operation which would warrant any apprehension of danger. Mr. Keene then gave an account of the post-mortem; the principal features of which were: that the

anterior surface of the heart was loaded with fat, that the posterior wall of the right ventricle was very thin, the muscle being here apparently encroached on by fat, but there was no fatty degeneration to be detected under the microscope. The aorta was dilated and rigid with atheromatous deposit. The right auricle was distended with almost fluid blood, the valves being healthy. The author remarked that the case suggested the following points for consideration :—1st. The preparatory stage for anæsthesia. 2nd. The selection of the anæsthetic. 3rd. The method of administration. 4th. The best means to adopt when dangerous symptoms arose.

On the first point he objected to the practice of causing the patient to abstain from the last meal, which, being dinner, practically came to keeping her twenty-four hours without substantial food. He advocated a more substantial breakfast and strong beef-tea; later, and in case of a patient exhibiting great fear, small doses of brandy might be given. Morphia and bromide of potassium, to lessen reflex irritability before the anæsthetic was administered, had been suggested, but he had not tried the plan.

On the second point he would request the opinion of the Society. It was the fashion to consider ether safer than chloroform or the methylene bichloride; but it occurred to him that, six or seven deaths having occurred in the short period when ether was first employed, and the occurrence of a fatal case lately, were not entirely favorable to its use.

On the third point there was a variety of practices. He advised giving the anæsthetic slowly, and humouring resistance on the part of the patient rather than overcoming it by resistance.

On the fourth point it might be objected that galvanism should have been employed, but Mr. Keene thought that it was more likely to lower the heart's action than to increase it, and the only means to be employed were, drawing out the tongue and practising artificial respiration. He would venture to ask for a full discussion from the Fellows on this important subject.

The PRESIDENT asked how it was that chloroform was given for the bichloride of methylene. Was it the manufacturer's fault?

Mr. GEORGE COWELL had had a case of death from chloroform in which, at the autopsy, the right ventricle had been found dilated, and the fibres undergoing fatty degeneration. From the fact of ten deaths from chloroform occurring together, he could not help thinking that atmospheric changes, especially the rise of tempera-

ture, had something to do with them. He regarded fear as a bad sign. If the heart stopped, nothing would excite it to contraction, but if the breathing became weak, artificial respiration might be of great use.

Dr. SUTRO suggested the injection of liquor ammoniæ into the veins, which had been so useful in snake-bites, and might be resorted to in these cases with good effect.

Mr. WM. ALLINGHAM gave an account of a death from chloroform which occurred at St. Mark's Hospital, and stated that in this instance the patient had taken chloroform before without difficulty, and he recalled three other instances, including one at the Western Ophthalmic Hospital, where this had been the case.

Mr. CARR JACKSON drew attention to the number of fatal cases occurring in the practice of a comparatively small number of practitioners.

Mr. NELSON HARDY begged to say that no death had occurred from chloroform at the Western Ophthalmic Hospital.

Mr. SEBASTIAN WILKINSON dwelt strongly on the different means of proceeding, and their difficulties.

Mr. BAILEY considered that Mr. Clover's was the best method, as it insured only four or five per cent. of chloroform being used at a time; and that it was important to remove the inhaler directly the patient had taken enough, as otherwise too much was absorbed.

Mr. HOGG stated that since the introduction of methylene bichloride by Dr. Richardson he had used nothing else. He had given it in 2000 cases rapidly; watching the patient, and using Junker's apparatus. He had never had an accident, and in an experience of twenty-three years he only remembered two deaths from chloroform at his hospital.

The debate was adjourned until Monday, the 20th inst.

April 20th, 1874.

VICTOR DE MÉRIC, Esq., President, in the Chair.

Mr. HENRY LEE showed a patient with a

SECONDARY ULCERATION OF THE EYELID.

The case was contrasted with the one of primary ulceration exhibited by Mr. Francis Mason at the last meeting of the Society. In Mr. Lee's case there was well-defined and circumscribed induration, the submaxillary glands were enlarged, and the ulcer, which was now healing, had a week before been more extensive. The patient had the cicatrix of a sore on the penis contracted between two and three months previously, which now formed a hard circumscribed nodule. The inguinal glands had become specifically enlarged a fortnight after the sore appeared, and three or four weeks later a very distinct syphilitic eruption appeared on the face and body. Last of all appeared the secondary ulceration of the eyelid, and this Mr. Lee maintained could not, independently of the history, have been distinguished from a primary ulceration. He mentioned that it would every now and then occur that a secondary ulceration was identical in appearance with a primary chancre. In secondary ulcerations, however, the corresponding absorbent glands were not often affected, but in this case they happened to be so. The induration in them might, however, as well have depended on the eruption of the face as on the ulceration of the eyelid. There was no enlargement of the cervical glands.

The PRESIDENT made some remarks on this case, and then called on Dr. Richardson, F.R.S., to reopen the adjourned debate on Mr. Keene's case of death from chloroform.

Dr. RICHARDSON remarked that in his opinion the death in Mr. Keene's case was due to chloroform. The fact was not to be attributed as a fault to the manufacturer of the fluid used by Mr. Keene, but to the difficulty of distilling methylene bichloride without the passing over of a certain amount of chloroform. Where the product was kept in a bottle which was frequently opened or loosely

stoppered, the lighter fluid escaped by evaporation, and the last portion of the fluid left in the bottle contained chloroform. To prevent this he suggested that the methylene should be dispensed in small bottles, until a more accurate method of producing it as a commercial article should be discovered. Dr. Richardson contended at the same time that methylene bichloride, though it might contain even as much as 30 per cent. of chloroform, is still safer than chloroform, and he adduced three reasons for its greater safety, viz. its lower specific weight, its lower boiling-point, and its containing one equivalent less of chlorine than chloroform. From this point Dr. Richardson proceeded to show that the dangers at present incident to anæsthesia are due, not to the process of anæsthesia, but to the imperfect methods by which the process is carried out. The tetanic convulsion, for instance, so often produced by chloroform has nothing to do with the insensibility, but is a specific and unnecessary danger superadded to the neurotic action of the agent. As yet some objection also existed in the case of every other agent, and it is therefore the duty of science to find a new anæsthetic, which shall annihilate pain and excite no more danger than is common to natural sleep. The dangers of chloroform were most felt by two distinct classes of persons. There exists a certain part of the population physically disposed to die from chloroform. Mr. Keene's patient was of this class. The right side of the heart was enfeebled, the heart over-burthened with fat, and the aorta was rigid. In such a patient, when the chloroform excites to contraction and resistance the minute vessels of the circulation, when there is resistance to the action of the heart in the lungs in the pulmonary circuit of the blood and also in the systemic circuit of the blood, it is less wonderful that, considering the aorta has lost its resiliency, the patient should recover, than that she should die. Dr. Richardson, after noticing that chloroform was sometimes not free from the heavier chloride, the tetrachloride of carbon, observed that, in addition to the persons physically disposed by disease to die from chloroform, there was a class of individuals who from organic nervous peculiarity were similarly disposed to die. These were persons of a passionate and emotional nature, who blanched readily with anger or fear, and could, as it were, by mere impulse produce contraction of the peripheral circulation and resistance to the propelling power of the heart. Such persons sometimes die from fear or passion, without chloroform, and when

this temperament is combined with disease of the heart and great vessels the danger of death is always imminent. Dr. Richardson agreed with Mr. Keene that it was bad practice to exhibit chloroform to a patient exhausted from long fasting, and he thought a little wine, before commencing the administration, advantageous. It was important to have the bowels freely open, and to place the patient so that during inhalation there should be no movement of the body, the semi-recumbent position being the best. As regards the mode of administration the speaker expressed his belief that, with ordinary prudence on the part of the administrator, one mode was as safe as another. He quoted a series of statistical facts in proof of this view, and while for the sake of conformity and public consistency he would support any reasonable and uniform method, he was convinced that the mortality would remain much as it was, until an improvement was discovered in the agents we use to produce anæsthesia. The treatment to be adopted in cases of apparent death from chloroform was discussed at length by Dr. Richardson, and the various experiments he had made of artificial respiration, transfusion of blood and of ammonia, of artificial circulation, and of electric excitation, were carefully narrated. The conclusion he had arrived at was, that artificial respiration, carried out with double-acting bellows, so that the body be not roughly moved, is the best of all plans for restoring animation. If anything is to be done in four minutes—the longest period the practitioner can hope to employ with any prospect of success—it is best done by gentle artificial respiration. Electrical discharge brought to bear upon the heart is more likely to arrest than to promote its action. Dr. Richardson concluded by a notice of the various agents he had experimented with in order to discover a safer and better anæsthetic, and he gave the theoretic formula for a wise and efficient chemical body of this kind. He had been recently experimenting with a substance called “Methylal,” and on a future occasion he would bring his results before the Society.

Mr. CLOVER thought Dr. Richardson's remarks as to the composition of commercial bichloride of methylene very important. A liquid containing 30 per cent. of chloroform, and liable to contain a larger amount by the evaporation of the lighter body, cannot be safely administered in the free manner in which it is frequently given. He had found it less uniform in its action than pure chloroform, and had ceased to make use of it. The adulteration of chloroform with

tetrachloride of carbon might easily be detected by smelling the residue of a few drops poured upon blotting-paper and allowed to evaporate. Before giving ether or chloroform, or compounds containing them, he thought patients should fast long enough to allow all food to have left the stomach. When the patient is feeble, a teaspoonful of brandy should be given half an hour before inhaling. If swallowed just before inhaling, it is liable to regurgitation and to produce spasm of the glottis. The patient should be comfortable, but he did not think there was much danger from a constrained position or tight dress, except so far as it interfered with the speedy establishment of artificial respiration. It is not so much from want of oxygen as from the presence of an anæsthetic in the blood that the heart stops. Free respiration of air strongly charged with chloroform is more dangerous than such a limited respiration of the same atmosphere as could be produced by a tight dress. He had found that a succession of full inspirations, followed by muscular effort and closed glottis, favoured the entrance of chloroform into the blood, and especially so if at the same time the circulation flagged. He advised that whenever the breath movements were exaggerated, special care should be taken that the atmosphere of chloroform should not be a strong one. If the blood circulates slowly in the lungs, as it does when the heart begins to fail, more chloroform is absorbed; therefore the administrator should fix his attention on the pulse and respiration, and the moment the pulse becomes feeble, he should lessen the chloroform or remove it. Even where the patient is strong and struggles, if the pulse cannot be distinctly felt, it is dangerous to go on with the chloroform. Admitting that some deaths under anæsthetics were inevitable, he could not agree with Dr. Richardson that the kind of apparatus for giving them was not very important. Many fatal cases were nearly rescued and would have been prevented, had they held 1 per cent. less of chloroform in the lungs, when the alarm was taken, and many cases of threatened death would have been fatal if the lungs had held 1 per cent. more than they did. Chloroform, beyond a certain strength, is rapidly fatal to animal life, and the more diluted with air the longer it takes to kill. Mr. Clover thought, therefore, that until we found an agent of which an overdose is not dangerous we had better make it impossible to give more than a moderate proportion, just enough, in fact, to produce the required effect, and he hoped a more suitable apparatus than his

own might be invented. He considered nitrous oxide the best anæsthetic for operations which could be quickly finished and required absolute quietude of the patient, the recovery being pleasant and quick. He now always gives nitrous oxide preparatory to administering ether. The patient is fit for operation in sixty seconds, knows nothing of the pungency of the ether, and tastes it less afterwards because a smaller quantity is used, and, consequently, is taken up by the tissues; but there are a number of operations where entire quietude of the patient for half an hour is required, and for these chloroform stands its ground.

Dr. THEODORE WILLIAMS remarked that Dr. Richardson held out a very gloomy prospect for the uses of anæsthetics in this and succeeding generations. A certain number of deaths from chloroform occurred, and as a certain number of persons unfitted to use anæsthetics would use them, it was not, according to Dr. Richardson, likely to diminish. So we had only to fold our arms like Orientals and utter "kismet," and make no attempt to prevent these catastrophes. To this Dr. Williams could not agree, and he thought that a really careful examination of the chest might often prevent them. It seemed to him that in Mr. Keene's case there should have been some muffling of the first sound of the heart in consequence of the fat-covered muscle, and the aorta rigid with atheroma might have caused a murmur. In resuscitation he was strongly in favour of artificial respiration, using, not air, but pure oxygen, and, if necessary, in desperate cases applying it directly to the lungs through an opening in the trachea, so as to prevent it going into the œsophagus. He was struck by two experiments made by the Medico-Chirurgical Committee, at which he assisted. Two dogs were given chloroform until respiration, and, in one case heart's action, ceased, and in the other nearly so. Oxygen was pumped vigorously into their lungs through an opening in the trachea for several minutes. The heart slowly, but gradually, began to beat, the respiration returned, and the dogs recovered. The experiment was tried with atmospheric air alone, but failed.

Dr. ROGERS at first used ether in midwifery, but after Dr. Snow introduced chloroform he had taken to it and had never had a fatal case. In three cases at his hospital, where death was apprehended, when the patients were pulseless and breathless, restoration through artificial respiration had taken place. He had known Dr. Squarey give ether in fatty heart cases with good effect.

Dr. ROUTH stated that in two out of three of Dr. Rogers's cases electricity as well as artificial respiration had been used, and with good effect. Had Dr. Richardson tried the interrupted current in these cases?

Mr. NAPIER considered that chloroform was given, as a rule, too rapidly, and the patient was forced too much in this country.

Dr. ROGERS wished to draw attention to the fact that he had given chloroform in very different amounts to the same patients to produce the same amount of anæsthesia.

Mr. HENRY LEE advocated giving chloroform on a sponge, and arranging it so that the patient dropped the sponge directly he became insensible.

Dr. LAUDER BRUNTON agreed with Dr. Richardson in thinking that artificial respiration afforded the only chance of recovery from apparent death from chloroform, and that stimulation of the heart by electricity was of little or no use. He had found from experiments on animals that when the heart had been fairly stopped by chloroform, neither acupuncture, galvanism, nor opening the vena cava were of any use, though he and Dr. Taylor had seen such a heart begin to pulsate after the apex of the right ventricle had been cut off. One important cause of death from chloroform was stoppage of the circulation through the lungs, which is produced in animals by concentrated but not by diluted chloroform vapour. He therefore thought that the administration of concentrated vapour to man should be avoided. Ether does not produce this effect, and it should be preferred to chloroform whenever the existence of a fatty heart is suspected. Another danger arose, especially in dental surgery, from anæsthesia being only imperfect when an operation was begun. The patient was thus subjected to the risk of shock, or, in other words, of having his heart stopped by the operation acting through the nerves on the heart or vessels. The application of an irritating vapour such as chloroform to the nose of a rabbit produced reflex stoppage of the heart through the fifth and vagus nerves. When the animal was completely anæsthetized and reflex action abolished, the heart could no longer be stopped in this way. He quoted Professor Syme's opinion that deep anæsthesia protected from danger, and instanced a case in dental practice, where a sparing use of the anæsthetic appeared to have led to fatal results. Operations on the stomach will induce death from shock in animals, even when rendered completely insensible by chloroform, but they did not when

ether was used, which was therefore preferable to chloroform in operations on the abdominal viscera.

Dr. FAYRER, as the hour was late and the subject a very important one, proposed that the debate be adjourned to next meeting.

The PRESIDENT said that in consequence of the large amount of agenda (including the reading of an abstract of the 'Fothergillian Essay') for next meeting, this would be impossible without infringing the laws of the Society. It was open to any member to move an extension of the meeting for half an hour.

Dr. FAYRER withdrew his motion.

Dr. ROUTH then proposed, and Mr. HOGG seconded, that the meeting be extended for half an hour.

This was carried, and the President called on Mr. Keene and Dr. Richardson to reply.

Mr. KEENE thanked the Society for the excellent discussion which his paper had evoked, and explained what he meant by regulating the food of the patient before anæsthesia. In reply to Dr. Williams, he stated that the patient's chest had been examined before the first administration of chloroform, and nothing wrong had been detected.

Dr. RICHARDSON, in reply to the various speakers, said that he had not found that artificial respiration with oxygen or other gases did better than with common dry air. He maintained, notwithstanding Mr. Clover's argument, that the danger of death lies, not in the mode of administration, but in the fault of the agent administered, and that we only deceive ourselves in thinking there is any hope of better success until a new and safer anæsthetic be discovered.

April 27th, 1874.

VICTOR DE MÉRIC, Esq., President, in the Chair.

Dr. DOWSE exhibited a specimen of

CANCER OF THE UTERUS TAKEN FROM A WOMAN,
ÆT. 45.

She suffered from cancer of the left breast fifteen years ago. This

was removed, and the disease attacked the right breast, and was at a later date in the liver and ovaries.

The PRESIDENT asked where the cancer developed—in the mammæ or in the internal organs? and also, was jaundice present?

Dr. HABERSHON remarked that internal cancer following cancer of the breast was common, but the reverse, viz. the development of the mammary from internal cancer, was rare. A curious feature in Dr. Dowse's case was the long duration of the disease, it having taken upwards of fifteen years to terminate life. Jaundice was by no means a necessary accompaniment of cancer of the liver, as this symptom might be absent during a whole life-history of the disease.

Dr. ROUTH inquired whether the uterus was clear of disease at the commencement of the patient's illness, as it was quite possible that cancer had commenced in that organ prior to its appearance in the breast.

Mr. ROYES BELL asked what grounds there were for ascribing the internal disease to scirrhus of the breast removed fifteen years ago.

Dr. DOWSE having replied,

Dr. SPENDER, of Bath, then read an abstract of his Prize Essay on
THERAPEUTIC MEANS FOR THE RELIEF OF PAIN,

to which the Fothergillian Prize had been awarded.

On the motion of Dr. HABERSHON, seconded by Dr. WILTSHIRE, a vote of thanks was given to Dr. Spender for his essay, which was briefly acknowledged by the author, who was also requested to publish it.

Dr. ROUTH then read a paper on

SOME NEW PREPARATIONS OF PHOSPHORUS, WITH
GENERAL REMARKS AS TO THEIR THERAPEU-
TICAL VALUE.

He stated that the paper was a corollary to his former communication on "Overwork and Premature Mental Decay."* He then had mainly spoken of two preparations of phosphorus, viz. the "solutio phosphori medicati," a solution of phosphorus in olive oil with a little mucilage and essential oil of the strength of one third grain of phosphorus to the drachm, and the phosphide of zinc, both used by Dr. Hammond, of New York. In speaking of the effects of phosphorus as

* See p. 19.

a drug, it was best to take this solution as a standard, and thus point out the differences in the action of the other preparations. Dr. Routh then spoke of the effects of phosphorus, which were those of a stimulant in small doses, sedative, and producing a pleasant sensation of warmth, relieving neuralgia, and effective against certain obstinate skin diseases, such as eczema and acne, and he thought it retarded the progress of cancer. It was also an aphrodisiac, and appeared to improve the mental qualities, if deteriorating. In larger doses it acted as an acrid poison, the peculiar feature being a burning sensation in the mucous tract, and whenever this symptom appeared it was a proof that the medicine had been carried far enough. On some persons it acted severely, producing even after the first dose sickness, faintness, and great stomach pain. Idiosyncrasy alone could account for this, and, possibly, decomposition. For these reasons Dr. Routh recommends the use of sperm oil or purified neat's foot in lieu of sweet almond oil; five drops of this solution added to a teaspoonful of cod-liver oil improves the action of the latter in proper cases. The phosphide of zinc has been said to be inert, because insoluble, but it is easily assimilated. Rubbed up in a mortar it emits the characteristic garlic odour, and burns spontaneously when thrown over a flame. It is a weak preparation, and has been safely given in doses of one grain three times a day. Like other preparations of phosphorus, it is apt to clog up the liver, and must then be suspended for a few days. Chloro-phosphide of arsenic is prepared by bringing pure hydrochloric acid into contact with phosphorus and arsenic in a fine state of division. While the phosphide is insoluble, the chloro-phosphide is very soluble. The solution is of a clear yellow-green and pleasant taste. It is decidedly antiperiodic and effective in cases of neuralgia. This solution contains 10 grains of arsenic and $16\frac{1}{2}$ of phosphorus to the ounce; the dose is therefore three to five minims *ter die*. It can be largely diluted, and the author prefers a solution that is regulated at fifteen drops for a dose. The syrup of phosphorus contains gr. $\frac{1}{10}$ in the $\mathfrak{z}\text{i}$. The phosphorus should be added in a pure state, and finely divided with caution. It is very nice to the taste; dose thirty to sixty minims. In cases of poisoning by phosphorus Dr. Routh recommends emetics and an antidote in the form of turpentine, and, in conclusion, remarked that the exhilarating effects of the drug gained upon patients, and care must be taken lest in this way we introduce a new form of dram drinking.

Mr. ASHBURTON THOMPSON then read a paper entitled
SUGGESTIONS FOR THE SAFE ADMINISTRATION OF
FREE PHOSPHORUS.

He began by remarking that the internal use of phosphorus was almost as old as the discovery of the element itself, and that the medical literature of the century dating from 1720 offered more essays on this than on any other single subject; yet the employment of this element as a remedy was never firmly established, its history presenting fluctuations in popular favour that are unknown in the history of any other remedy. These fluctuations suggest that an element of danger attended the very great remedial properties it was found to possess. That this was the case was evidenced by the record of its use, where more than one case of fatal poisoning can be found. The author then alluded to the recorded experiences of Drs. Hughes Bennett, Eames, Cotton, and Broadbent, who gave phosphorised oil in doses equivalent to from $\frac{1}{40}$ th to $\frac{1}{8}$ th grain of free phosphorus in an aggregate number of fifty-two cases, with the frequent occurrence of abdominal derangement; then to his own experience of nine cases, in every one of which symptoms of poisoning had been observed, slight in all but one, in which death was hourly expected for three days. He then recited two cases of great interest, one already reported in the 'Lancet' by Mr. Reedale:—A child, ten years old, took for twenty-three days $\frac{3}{5}$ ths to $\frac{9}{10}$ ths grains of solid phosphorus and the etherial solution daily without evincing any serious symptoms, but did so after the fifth dose of $\frac{5}{6}$ th grain dissolved in oil. The other case was reported by Solon:—A male adult took $\frac{1}{2}$ grain of phosphorus in ether every twenty-four hours for nine days, and yet died of less than 1 grain dissolved in oil and taken during thirty-six hours. He stated that others besides himself had found that a dose of phosphorus, poisonous when dissolved in oil, might be far exceeded if dissolved in ether and alcohol, while the excellent results obtained with the latter preparations testified to their activity. No case with the last-named solution had been recorded. Mr. Thompson then considered what chemical change might account for the exhibition of unexpected toxic power on the part of phosphorised oil, and he asserted that phosphorised cod-liver oil might be given with the same safety as phosphorised ether or alcohol, and in the same doses. The main difference between this fish-oil and the vegetable (almond or olive) oils generally employed

was that the latter absorbs very large proportions of air. As phosphorus oxidised very easily this absorption exposed the element to change. Freely exposed to air phosphorus passed rapidly into phosphoric acid, a harmless medicine; but it seemed plausible to the author to imagine that the density of vegetable acids, together with the peculiar manner in which they present oxygen to phosphorus, might serve to delay the element in its lowest and first stage of oxidation, viz. as hypo-phosphorus acid. The author then reviewed the important characteristics of this body, viz. causticity, its extreme avidity for oxygen, the ease with which it is absorbed, and alluded to a remark of Devergie's, which showed that he had regarded their transformation as the cause of poisoning in Solon's case, and to Personne's recent experiments, which show that phosphorus dissolved in hypophosphorous acid is most readily absorbed, and becomes imbued with toxic powers quite out of proportion to the actual quantity of free phosphorus present. The author alluded to the possible influence of idiosyncrasy, but briefly stated that, having watched more than 400 cases treated with this drug, and having carefully considered most of the hitherto recorded observations, he did not feel satisfied that any peculiar idiosyncrasy with regard to it existed, but he awaited the result of further expression. The solutions of phosphorus in vegetable oils do not, for the reasons stated, afford a safe means of exhibiting free phosphorus. The manner of preparing the oil in France consisted in heating it to about 560° F., and in England to 300°, which certainly drove off the air and water suspended in the oil, but did not avoid the dangers, which must arise in the manner described, from absorption of fresh portions of air and aqueous vapour, and therefore the author declined to use phosphorised vegetable oil any longer. He referred to the absorption of solid phosphorus by the stomach, and deduced the rule that it should be taken with food. Of zinc phosphide, he said that since it acted only after decomposition by the acids of the stomach, it followed that many doses might accumulate and remain unchanged if the secretions of that organ were alkaline. If the accumulation were then suddenly brought in contact with acid, symptoms of poisoning would occur. This had happened in a case noted by Professor Gubler. The obvious and very necessary precaution consisted in the use of an acidulated tonic with each dose of the drug or the dietetic employment of lemonade during the medication. Mr. Thompson concluded by stating that these rules, though simple,

had never been formulated before, and he believed that ignorance of the facts on which they are founded had conferred on free phosphorus a reputation for treacherously poisonous qualities, even in remedial doses. These had never been enunciated, and in reality appertained (in the case of phosphorised vegetable oil, at least) to an unsuspected admixture of combined (oxidized) phosphorus.

A FELLOW endorsed the observations of Dr. Routh and Mr. Thompson, and had left off giving phosphorus in vegetable oil, because he found it gave rise to intestinal irritation. He had tried phosphide of zinc, always giving it on a full meal, also some phosphorous pills, manufactured by Messrs. Kirby, and had heard no complaint from their use.

Dr. WILTSHIRE remarked that the phosphorous pills were generally made up with resin, which rendered them quite insoluble in the stomach, and this accounted for their harmlessness. He had tried the drug in capsules, each containing one third of a grain, with good results.

Dr. BRUNTON agreed with Mr. Thompson's remarks about the different effects of phosphorus when combined with the cod-liver and vegetable oils.

Dr. HARE did not approve of giving strong drugs, like opium, arsenic, and phosphorus, in pills, as they sometimes accumulated in the stomach.

Dr. THEODORE WILLIAMS agreed with Dr. Hare on the pill question, and stated that though he had no large experience of free phosphorus, he had used the hypophosphites of lime and soda—one form of oxidized phosphorus—largely, with some advantages, and certainly with no danger to the patient. That these preparations were not likely to be inert was shown by placing them in a flame, when they would burn in a similar manner to phosphorus itself, and he was inclined to think that this was a very safe way of giving phosphorus in a slightly oxidized form. He thanked Dr. Routh for suggesting a good vehicle for the drug in the form of syrup, which seemed very palatable.

Dr. SEPTIMUS GIBBON had used phosphorous pills for twenty-two years, and found that the drug was easily dissolved in bisulphide of carbon.

Dr. ROUTH and Mr. ASHBURTON THOMPSON replied.

May 4th, 1874.

VICTOR DE MÉRIC, Esq., President, in the Chair.

THE ANNUAL ORATION AND CONVERSAZIONE.

The ANNUAL ORATION was delivered by Mr. BRUDENELL CARTER to a crowded audience. The subject chosen was

THE WASTE OF LIFE BY PREVENTIBLE MEANS.

At the conclusion a vote of thanks to Mr. Carter was proposed by Dr. Habershon, seconded by Dr. Wiltshire, and carried by acclamation.

The CONVERSAZIONE then took place, which was remarkable for the variety of works of art and science exhibited, and for the numbers who attended.

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